# Standards of Practice: School Health Services

VERMONT
DEPARTMENT OF EDUCATION
**120 State Street**
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## FORWARD

We are pleased to present the August 2005, revised Vermont Standards of Practice: School Health Services Manual as a statement of Best Practices for school nursing. It was developed and published under the leadership of the Vermont Department of Education in collaboration with the Vermont Medical Society, the Vermont State School Nurses Association, the Vermont Department of Health and the Vermont State Board of Nursing.

This manual provides guidance to school administration and school nurses in the development, implementation and evaluation of high quality school health services.

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## HOW TO USE THIS MANUAL

This manual is divided into 31 sections. In each section, there is a short statement of purpose followed by the authorization/legal reference which supports it and definitions when appropriate. Sections describing suggested and required roles of the school nurse cover the school nurse and the associate school nurse respectively. Next is a list of local and national resources and sample polices, procedures and forms that you may find useful in the implementation of your school health program. Copies of the authorizations and legal references are located in the back of the manual in alphabetical/numerical order.

Because there will be additions and revisions to this manual over time, we are not numbering the pages. When revisions are made we will notify all school nurses via e-mail and put the revised documents on the Vermont Department of Education website.

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# ADULT HEALTH SERVICES

## STATEMENT OF PURPOSE:

All schools should encourage personnel to maintain optimal physical and mental health.

## AUTHORIZATION/LEGAL REFERENCE:

12 V.S.A. Chapter 23 § 519 - Emergency Medical Care

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Maintain emergency information on employees.
2. Encourage staff to have periodic physical examinations at their medical home.
3. Serve as a resource person for employees with health concerns and refer as needed.
4. Serve as a resource for health promotion programs for staff (i.e. blood pressure screening, breast self-examination, and others as requested by staff).
5. Support the participation of employees in the annual Vermont School Board Insurance Trust PATH Program.
6. Provide emergency first aid as necessary.
7. Facilitate and assist in assuring safety in the workplace setting.

## RESOURCES:

- American Cancer Society of Vermont - http://www.cancer.org/docroot/home/index.asp
- American Lung Association of Vermont - http://lungaction.org/ala_vt/home.html
- Domestic Violence Hotline – 1-800-228-7395
- Vermont Department of Children and Families - http://www.dcf.state.vt.us/
- Vermont Department of Health - http://www.healthyvermonters.info/
- Vermont School Board Insurance Trust - http://www.vsbit.org/
- Women's First - http://www.forwoman.net/

## SAMPLE POLICIES, PROCEDURES AND FORMS

Personnel Health/Emergency Form

**Personnel Health/Emergency Form**
**CONFIDENTIAL**

NAME: _____ HOME PHONE: _____

HOME: _____

IN CASE OF EMERGENCY, CONTACT THE FOLLOWING:

1. _____ PHONE_____

2. _____ PHONE_____

Primary Care Provider _____ Date of Last Visit_____☐ None

Dentist _____ Date of Last Visit_____☐ None

**EXPLAIN ANY OF THE FOLLOWING MEDICAL PROBLEMS WHICH APPLY TO YOU:**

Allergies (food, medicine, latex or environmental) _____

Asthma _____

Diabetes _____

High blood pressure _____

Heart problems _____

Digestive problems, ulcers _____

Hearing or vision problems _____

Other _____

LIST ANY MEDICATIONS TAKEN ON A DAILY BASIS: _____
_____

HAVE YOU HAD CHICKEN POX OR THE VACCINE? _____

HAVE YOU BEEN IMMUNIZED FOR HEPATITIS B? _____

HAVE YOU HAD A TETANUS BOOSTER IN THE LAST 10 YEARS? _____

Signature _____Date_____

# ALLERGIES – LIFE THREATENING

## STATEMENT OF PURPOSE:

All schools should have trained personnel able to respond to a student/staff member having a severe allergic reaction. Written allergy emergency health care protocols should be readily available.

## AUTHORIZATION/LEGAL REFERENCE:

- 12 V.S.A. Chapter 23 § 519 - Emergency Medical Care
- 26 V.S.A. Chapter 28 – Nurse Practice Act
- Vermont School Quality Standards, Section 2120.8.1.3.3

## DEFINITION:

**Severe Allergic Reaction -** A reaction ranging in response from a diffuse rash, to swelling of oral pharynx, to bronchial spasm, to shock, collapse and cardiac/respiratory arrest.

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Gather and verify allergy information with parents and physician.
2. Develop Individual Health Plan/Protocol for children with known allergies.
3. Obtain needed medication from the parent.
4. Train staff and document staff training for response to allergic emergency situations.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Educate school community about allergic reactions and treatment.
2. Collaborate with administration to develop preventative measures (i.e., peanut-safe areas, screens on windows, etc).
3. For unknown allergies develop a protocol to be used only by the nurse with the school physician's authorazation and have both the physician's and nurse's signatures on the document. Obtain a written medical order for the EpiPen and/or EpiPen Jr. annually and stock an up-to-date syringe of the medication.

## RESOURCES:

- Food Allergy Network - (703) 691-3179, http://www/foodallergy.org
- "School Food Allergy Program" 1995. Video and reference book that assists in disseminate information about life threatening food allergies can be loaned through the Vermont Health Education Resource Centers http://www.state.vt.us/educ/new/html/pgm_coordhealth/herc/herc.html

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

- Emergency Health Care Plan
- EpiPen Directions
- Treatment Procedures for Known Hypersensitivity
- Treatment Procedures for Unknown Hypersensitivity

Place Child's Picture Here

# EMERGENCY HEALTH CARE PLAN

**ALLERGY TO:** _____

Student's Name: _____ D.O.B. _____ Teacher: _____

Asthmatic: Yes* ☐ ☐ No *High risk for severe reaction

◆ **SIGNS OF AN ALLERGIC REACTION** ◆

| **Systems:** | **Symptoms** |
|---|---|
| • **MOUTH** | itching & swelling of the lips, tongue, or mouth |
| • **THROAT*** | itching and/or a sense of tightness in the throat, hoarseness, and hacking cough |
| • **SKIN** | hives, itchy rash, and/or swelling about the face or extremities |
| • **GUT** | nausea, abdominal cramps, vomiting, and/or diarrhea |
| • **LUNG*** | shortness of breath, repetitive coughing, and/or wheezing |
| • **HEART*** | "thready" pulse, "passing out" |

**The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.**

◆ **ACTION FOR MINOR REACTION** ◆

If only symptom(s) are: _____, give _____Medication/dose/route _____

Then call:

1. Mother _____, Father _____, or emergency contacts
2. Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps 1-3 below.

◆ **ACTION FOR MAJOR REACTION** ◆

If ingestion is suspected and/or symptom(s) are: _____give _____ **IMMEDIATELY!**

Then call:
1. Rescue Squad (ask for advanced life support)
2. Mother _____, Father _____ or emergency contacts.
3. Dr. _____ at _____

**DO NOT HESITATE TO CALL RESCUE SQUAD!**

---

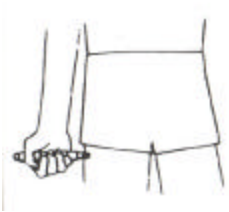
_____ _____ _____ _____
Parent's Signature Date Doctor's Signature Date

| **EMERGENCY CONTACTS** | **TRAINED STAFF MEMBERS** |
|---|---|
| 1. _____ | _____ Room _____ |
| Relation: _____ Phone: _____ | |
| 2._____ | _____ Room _____ |
| Relation: _____ Phone: _____ | |
| 3._____ | _____ Room _____ |
| Relation: _____ Phone: _____ | |

# EPIPEN® AND EPIPEN® JR. DIRECTIONS

**1. Pull off gray safety cap**


**2. Place black tip on outer thigh (always apply to thigh)**



**3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.**

## TREATMENT PROCEDURE FOR KNOWN HYPERSENSITIVITY:

If an exposure occurs or is strongly suspected to have occurred ***begin treatment immediately.*** Do not wait for symptoms to develop.

- Monitor and maintain ABCs (airway, breathing, circulation) as needed.
- Administer oral diphenhydramine (dosage as prescribed by student's medical home).
- Administer epinephrine (dosage as prescribed by student's medical home).
- Nurse will administer epinephrine. Epinephrine 1:10,000u
- Administer **EpiPen** for students **over 40 lbs** E= .3mg/cc .3cc
- **EpiPen Jr.** for students **under 40 lbs** E= .15/cc .3cc
- Administer oral steroid (dosage as prescribed by student's medical home).
- Diligently observe student.
- Activate EMS and transport to ER for further treatment.
- Notify medical home and parents.

## TREATMENT PROCEDURE FOR UNKNOWN HYPERSENSITIVITY:

**Protocol for: Unknown Allergy and Anaphylactic Reaction to Bee Sting or Other Irritants**

The following protocol authorized by Dr. _____is for the administration of epinephrine by the school nurse/associate school nurse to a student who is having an anaphylactic reaction and has no order for epinephrine from their physician. Assessment of the presences of an anaphylactic reaction and determination of the need for epinephrine will be done by the school nurse/associate school nurse who will be following the protocol described below.

1. Remove stinger - scrape gently with finger nail - then apply ice
2. Observe for allergic reaction for a least one half an hour:
   - Complaining of "not feeling right"
   - Mild to severe itching - especially eyes, ears and throat
   - Coughing and sneezing
   - Facial edema (swelling) - (not at sting site) around eyes, lip, cheeks and neck
   - Generalized hives or erythema
   - Severe fright
   - Headache
   - Abdominal cramps or diarrhea
   - Nausea & vomiting
   - Hypotension due to vascular collapse or peripheral edema
   - Rapid pulse
   - **SIGNS OF AIRWAY CLOSURE**: Difficulty breathing; Shortness of breath; Feeling of fullness in throat; Change in voice quality; Wheezing; Stridor

**If above symptoms appear: proceed to step three immediately - symptoms beginning within 15 minutes of exposure to irritant result in more severe reactions**

3. Call emergency squad and parent - extra person should do this - remain calm with child to reassure.
4. Draw up and administer Epinephrine - *Epinephrine Dosage - children over 40lbs.
   - Give .3ml SC 1:1000 dilution
   - Injection Site - lateral middle one third of the thigh - if clothing and need for speed makes this site impractical use lateral middle one third of upper arm. Massage area after injection.
   - Epinephrine is excreted in urine in 20 min. therefore repeat injection every 15-20 min. as needed
5. If parent is unavailable, have a school employee with written description of the incident and copy of health record accompany student to emergency room with emergency squad.

Approved by: _____, M.D.

_____, R.N.

# BLOODBORNE PATHOGENS AND UNIVERSAL PRECAUTIONS

## STATEMENT OF PURPOSE:

All schools are required to have a bloodborne pathogens exposure control plan. Universal precautions are to be utilized with all students and with any exposure to blood or bodily fluids.

## AUTHORIZATION/LEGAL REFERENCE:

- 21 V.S.A. Chapter 3 § 201 – Occupational policy
- 21 V.S.A. Chapter 3 § 224 – Rules and standards
- 29 CFR 1910.1030 – Bloodborne Pathogens

## DEFINITION:

**Bloodborne Pathogens Exposure Control Plan** - A plan which defines the employees who may incur occupational exposure to blood or other potentially infectious materials, the response to possible contamination and hazards and section on training.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Review and revise as needed the school's bloodborne pathogens exposure control plan.
2. Develop safe practices for disposal of needles, other sharps and contaminated waste.
3. Develop protocol for use of protective equipment for cleaning of blood and body fluid spills and proper disposal of same.
4. Ensure that the sink used for cleaning of blood injuries is located away from refrigerator, medicine cabinet and any eating surfaces.
5. Develop protocol with administration and athletic director for response to injuries involving blood during athletic events.
6. Collaborate with administration to provide annual training as required by OSHA.
7. Provide information to students/staff about safe practices when injuries occur on the school grounds or school bus.

## RESOURCES:

Vermont Department of Occupational Safety and Health (VOSHA) - http://www.state.vt.us/labind/vosha.htm

## SAMPLE POLICIES, PROCEDURES AND FORMS:

- Sample HIV Policy
- Universal Precautions Guidelines in School Setting
- Bloodborne Pathogens Sample Exposure Control Plan

# Sample Comprehensive HIV* Policy for Schools: Pre-K - 12

## Includes:

- **General Provisions**
- **Confidentiality, Disclosure, and Testing**
- **Education and Instruction**
- **Exposure to Bloodborne Pathogens and Universal Precautions**
- **Enforcement**
- **Appendices:**
  - **Procedures for Maintaining Confidentiality and Sample Written Consent Form**
  - **Universal Precautions**
  - **Annotated Legal References**
  - **Resources for HIV/AIDS Assistance and Information**

**Human Immunodeficiency Virus* **10/95**

# Comprehensive HIV Policy for Schools: Pre-K - 12

The Human Immunodeficiency Virus is not transmitted through casual contact and, therefore, is not reason in itself to treat individuals having or perceived as having HIV differently from other members of the school community. Accordingly, with respect to HIV disease, including acquired immune deficiency syndrome (AIDS), the _____ School District recognizes:

- the rights of students and employees with HIV,
- the importance of maintaining confidentiality regarding the medical condition of any individual,
- the importance of an educational environment free of significant risks to health, and
- the necessity for HIV education and training for the school community and the community-at-large.

## A. General Provisions:

1. The school district shall not discriminate against or tolerate discrimination against any individual who has or is perceived as having HIV.

2. A student who has or is perceived as having HIV is entitled to attend school in a regular classroom, unless otherwise provided by law, and shall be afforded opportunities on an equal basis with all students.

3. No applicant shall be denied employment and no employee shall be prevented from continued employment on the basis of having or being perceived as having HIV. Such an employee is entitled to the rights, privileges, and services accorded to employees generally, including benefits provided school employees with long-term diseases or disabling conditions.

## B. Confidentiality, Disclosure and Testing:

### Provisions Reflecting Present Legal Requirements

1. A student or student's parent/guardian, or an applicant/employee may, but is not required to, report HIV status to any school personnel.

2. Except as otherwise permitted by law, no school personnel shall disclose any HIV-related information, as it relates to prospective or current school personnel or students, to anyone except in accordance with the terms of a written consent. The superintendent shall develop a written consent form (see Appendix A) which details the information the signatory permits to be disclosed, to whom it may be disclosed, its specified time limitation, and the specific purpose for the disclosure. The school district shall not discriminate against any individual who does not provide written consent.

3. No school official shall require any applicant, employee, or prospective or current students to have any HIV-related test.

### Additional Provisions for Consideration

1. The superintendent shall develop procedures which ensure confidentiality in the maintenance and, where authorized, dissemination of all medically-related documents. (See Appendix A.)

## C. Education and Instruction

### Provisions Reflecting Present Legal Requirements

1. HIV is not, in itself, a disabling condition, but it may result in conditions that are disabling. To the extent that a student who has HIV is determined to meet the criteria for eligibility for accommodations under state and

federal non-discrimination laws or for special education services, the school district shall meet all procedural and substantive requirements.

2. The school district shall provide systematic and extensive elementary and secondary comprehensive health education which includes education on HIV infection, other sexually transmitted diseases as well as other communicable diseases, and the prevention of disease, as required by state law.

**Additional Provisions for Consideration**

1. The school district shall provide age-appropriate, ongoing HIV instruction, in accordance with the Vermont Department of Education *Guidelines for the Development of an HIV/AIDS Education Program in Vermont Schools.* This instruction shall include current HIV epidemiology, methods of transmission and prevention, universal precautions, and psycho-social aspects of HIV as part of a skills-based comprehensive health education program and through its integration into other subject areas.

2. The superintendent shall designate a coordinator to oversee the district's HIV education plans and programs.

3. The school board shall establish a comprehensive health education community advisory council to assist the school board in developing and implementing comprehensive health education including HIV education. The school board shall provide public notice to the community to allow all interested parties to apply for appointment. The school board shall endeavor to appoint members who represent various points of view within the community regarding comprehensive health education.

4. The superintendent or his/her designee shall create a plan to ensure that all school employees, including newly hired staff, receive training regarding current HIV epidemiology, methods of transmission and prevention, universal precautions, psycho-social aspects of HIV, related school policies and procedures, and where appropriate, teaching strategies. The superintendent shall report annually to the school board regarding implementation of this plan.

5. The school district shall provide for parents, families, students and the community, opportunities for education, discussion, and the development of recommendations about a systematic and comprehensive HIV prevention plan (including the promotion of abstinence, condom availability, and compassion for people living with the disease). Educators, administrators, and health professionals shall be involved in such activities.

**D. Exposure to Bloodborne Pathogens and Universal Precautions:**

**Provisions Reflecting Present Legal Requirements**

1. The school district shall comply with applicable Vermont Occupational Safety and Health Administration (VOSHA) rules in order to protect employees who are reasonably anticipated to be exposed to bloodborne pathogens as part of their regular job duties.

2. The superintendent or his/her designee shall determine those employees (by job class and possibly by task or procedure) who are reasonably anticipated to have occupational exposure to blood or other potentially infectious materials as part of their duties. These employees will be protected in strict accordance with the provisions of the Bloodborne Pathogens Standards.

**E. Enforcement:**

**Provisions Reflecting Present Legal Requirements**

1. A person who violates this policy may be subject to remedial and/or disciplinary action in accordance with applicable laws, collective bargaining agreements, policies, and/or disciplinary codes.

**Additional Provisions for Consideration**

1. Students and all staff not covered by the Bloodborne Pathogens Standard shall be instructed to avoid contact with potentially infectious materials and blood and shall immediately contact a member or the staff who is covered by the exposure control plan. When this is not possible, any person providing assistance shall follow universal precautions (see Appendix B).

2. The superintendent or his/her designee shall provide training to all staff and students about: the hazards of bloodborne pathogens; the recommended operating procedures of universal precautions; the existence of the VOSHA required exposure control plan; individuals or job classes to be notified in order to safely handle or clean up a blood or other body fluid spill safely; and the location and use of appropriate protective equipment and first aid devices.

3. The superintendent or his/her designee shall provide training on the recommended operating procedures of universal precautions to teaching substitutes and school volunteers.

Legal References: (See Appendix for Annotated Legal References)
1 V.S.A. § 317(b)(7) and (11)
Section 504 of the Rehabilitation Act of 1973
18 V.S.A. § 1127
Individuals with Disabilities Education Act (IDEA)
Title VI, Civil Rights Act of 1964, and as amended by the Equal Employment Act of 1972
American with Disabilities Act, P.L. 101-355 (1990)
16 V.S.A. § 131 et seq., § 906
Occupational Safety and Health Act of 1970
Occupational Exposure to Bloodborne Pathogens Standard (29 C.F.R. § 1910.1030
21 V.S.A. § 201©(2) and § 224

# **Appendices**:

**Appendix A**

Procedures for Maintaining Confidentiality and Sample Written Consent Form

**Appendix B**

Universal Precautions

**Appendix C**

Annotated Legal References

**Appendix D**

Resources for HIV/AIDS Assistance Information

**Appendix A**

## Procedures for Maintaining Confidentiality

To maintain an atmosphere of trust with staff members, students, families, and the community, a policy that encourages confidentiality is essential. It is important that people who have the Human Immunodeficiency Virus (HIV) and their families feel certain that their names will not be released against their wishes to others without a need to know. A policy on confidentiality that is strictly enforced will also provide protection to the school district from legal action and from potentially adverse reactions that might result.

To promote confidentiality and to avoid the violation of state and federal laws that protect the confidentiality of medical records, the following procedures are suggested:

1. All medical information in any way relating to the HIV status of any member of the school community, including written documentation of discussions, telephone conversations, proceedings, and meetings shall be kept in a locked file. Access to this file shall be granted only to those persons identified in writing by the student or student's parent/guardian, or the employee, as having a direct need to know. Filing and photocopying of related documents may be performed only by persons named in the written consent.

2. No medical information shall ever be faxed.

3. Medically-related documents that are to mailed shall be marked "Confidential." Names of persons mailing documents and those receiving the documents shall be identified on the written consent form by the student or student's parent/guardian, or the applicant/employee.

4. A written consent form shall be completed prior to each disclosure and release of HIV-related information (sample attached).

5. Each disclosure made shall be noted in the student or employee's personal file. The list of such disclosures shall be made available to the student, parent/guardian, or employee upon request.

6. Schools shall comply with Vermont Occupational Safety and Health Administration (VOSHA) rule §1910.20 which concerns maintenance of and access to employee medical records. [Note: §1910.20 is incorporated by reference into §1910.1030 (h).]

## Sample Written Consent Form for Each Release of Confidential HIV*Related Information

Confidential HIV-Related Information is any information that a person had and HIV-related test, has HIV infection, HIV-related illness or AIDS*, or has been potentially exposed to HIV. If you sign this form, HIV-related information can be given to the people listed and for the reasons listed below.

| |
|---|
| Name and address of person whose HIV-related information can be released: |
| Name and address of person signing this form (if other than above):<br><br>Relationship to person whose HIV-related information may be released: |
| Name, title or role, and the address of each person who may be given HIV-related information (include names of persons responsible for photocopying and filing confidential information):<br>1.<br>2.<br>3.<br>4.<br>5.<br>Additional names and addresses can be attached or listed on back.) |
| Information to be provided: (Check as many as apply.)<br><br>_____ HIV antibody test result<br>_____ AIDS diagnosis<br>_____ summarized medical record<br>_____ details of symptoms, signs, and/or diagnostic results<br>(specify: _____)<br>_____ psychiatric, other mental health, and/or developmental evaluation records<br>(specify: _____)<br>_____ names of medical care and/or support service providers<br>(specify: _____)<br>_____ infection status of other family members [Requires written consent]<br>_____ student's instructional program<br>_____ other (specify:_____) |
| Specific purpose(s) for release of HIV-related information |
| Time during which release of information is authorized: (A specific time must be noted for each single incidence of release of HIV-related information. Use a new form for each incident.)<br><br>From: To: |

Any disclosure of information not meeting the conditions listed above is expressly prohibited. Disclosure to any other persons than those listed above requires my informed, written consent.

Signature _____ Date _____

*Human Immunodeficiency Virus (HIV) that causes Acquired Immune Deficiency Syndrome (AIDS)

**Appendix C**

## Annotated Legal References

1. 1 V.S.A §317 (7) and (11) - Subsections (7) and (11) are two exceptions to the Vermont law requiring disclosure of public records. Subsection (7) deals with medical records of employees and subsection (11) deals with student records at public schools.

2. Section 504 of the Rehabilitation Act (29 U.S.C. §794) - This federal law (popularly known as "Section 504") prohibits discrimination against persons with disabilities by entities receiving federal funds.

3. 18 V.S.A. §112 7 - This Vermont public health law prohibits school districts from requiring HIV testing of any applicant, or prospective or current students and prohibits discrimination against an applicant, or prospective or current student on the ground that the person has tested HIV positive.

4. 21 V.S.A. §495(a)(6) and (7) - These provisions prohibit employers, employment agencies, labor organizations and persons seeking employees from discriminating against persons who have a positive test result on an HIV-related blood test and from requiring employees or prospective employees to take an HIV-related blood test as a condition of employment, membership, classification, placement or referral.

5. Individuals with Disabilities Education Act (20 U.S.C. §1400, et seq..) - This federal law (popularly known as "IDEA" or "P.L. 94-142") requires states and school districts to provide special education and related services to eligible students with disabilities.

6. Title VI, Civil Rights Act of 1964 as amended by the Equal Employment Act of 1972 (42 U.S.C. §§2000d and 2000e) - These federal provisions authorize enforcement of Section 504 through the federal courts by clarifying that 11$^{th}$ Amendment immunity is unavailable in such cases and makes available administrative remedies to aggrieved parties. Further, these provisions provide the enforcement mechanisms for violations of the Americans with Disabilities Act.

7. Americans with Disabilities Act (42 U.S.C. §12101, et seq.) - This federal law (popularly known as the "ADA") prohibits discrimination in, among other areas, employment and education on the basis of a disability.

8. 16 V.S.A. §131, et seq. and 16 V.S.A. §906 - These Vermont laws require each public and independent school to provide students with a minimum course of study in "comprehensive health education," including education on "HIV infection, other sexually transmitted diseases, as well as other communicable diseases, and the prevention of disease." Additionally, these laws permit the appointment of a community advisory council to assist school boards in developing and implementing comprehensive health education programs.

9. Occupational Safety and Health Act of 1970 - This federal law (popularly known nationally as "OSHA" and in Vermont as "VOSHA") requires safe working conditions in places of employment. In particular, 29 U.S.C. §§653, 655, and 657 form the basis for the issuance of OSHA regulations on dealing with bloodborne pathogens in the workplace.

10. Occupational Exposure to Bloodborne Pathogens Standard (29 C.F.R. §1910.1030) - This federal regulation requires employers to develop and maintain a written Exposure Control Plan concerning bloodborne pathogens and requires the taking of "universal precautions."

11. 21 V.S.A. §§201 and 224 - These state statutes make Vermont law on Occupational Safety and Health consistent with the federal Occupational Safety and Health Act of 1970 (see paragraph #9 above).

**Appendix D**

## Resources for HIV/AIDS Assistance and Information

### State Resources

Vermont Department of Education
**(802) 828-5151**
For local assistance, contact the Health Education Resource Center nearest you:
Brattleboro - **(802) 254-4511**
Colchester - (**802**) **854-4789**
St. Johnsbury - (**802**) **748-8640**

Vermont Department of Health (Hotline)
**800-882-AIDS**
The Hotline provides information and referral about all HIV-related issues.

Vermont Occupational Safety and Health Administration (VOSHA)
**800-640-0601**
A division of the State Health Department that supports and regulates workplace safety.

### American Red Cross Vermont Chapters

Serve all groups. Wide variety of informational resources available at low or no cost, including videos, curricula, and public health materials. Speakers and trainings also available. Subjects covered include: HIV transmission and prevention, AIDS in the workplace, confidentiality, universal precautions, bloodborne pathogens and exposure control planning, and first aid.

- Green Mountain - (**802**) **442-9458** (Bennington)
- Northern Vermont - **800-660-9130**
- Central Vermont - (**802**) **223-3701**
- Orleans Upper Essex - (**802**) **334-8065**
- Windham Area - **(802) 254-2377**

### AIDS Service Organizations

These organizations may provide some of the following services: Educational programs and training, speaker's bureaus, support and services for people affected by HIV/AIDS; and/or community advocacy. Contact the organization closest to you.

AIDS Community Resource Network (ACORN)
serving Windsor and Orange Counties
**(603) 448-2220**

AIDS Community Awareness Project (ACAP)
serving Caledonia, Essex and Orleans Counties
**(802) 748-1149** (St. Johnsbury)

Bennington Area AIDS Project
serving Bennington County
**800-845-AIDS**

Brattleboro Area AIDS Project
serving Windham and Southern Counties
**(802) 254-4444**

Vermont C.A.R.E.S.
serving Chittenden, Addison, Rutland, Lamoille, Washington, Frankly, and Grand Isle Counties
**(802) 863-AIDS** (Office and general hotline)

Vermont PWA (People With AIDS) Coalition
**800-698-8792 or (802) 222-5123**
The Coalition is a statewide organization of and for people living with HIV. The Coalition frequently provides HIV+ speakers for schools.

# Universal Precautions in the School Setting

***Reduce risk of exposure to bloodborne pathogens by using universal precautions to prevent contact with blood and body fluids. ****

## Begin by attending to the injured person:

Whenever blood and body fluids are present, a barrier (latex rubber gloves**, thick layer of paper towels, or cloth) should be used to minimize exposure of the attending person while the injury is cleansed and/or dressed.

Soiled clothes of the injured person must be bagged to be sent home.

Place waste in a plastic bag for disposal.

Remove gloves and dispose in plastic bag

Thoroughly wash hands with soap.

## Clean and disinfect environmental surfaces:

Whenever cleaning and disinfecting environmental surfaces in which blood and body fluids are present, a barrier (rubber utility gloves durable enough to withstand environmental cleaning and disinfecting, thick layer of paper towels, or cloth) should be placed between the blood and the attending person.

Disinfect the affected area(s) and cleaning tools with a commercial tuberculocidal disinfectant (mixed according to manufacturer's specifications) or bleach solution (approximately 1/4 cup common household bleach per gallon of tap water, mixed fresh daily). [2] The affected surface being disinfected should remain wet for several minutes.

Use disposable paper towels or other disposable materials to remove blood and body fluids.

Secure all waste in a plastic bag for disposal.

## Clean up for attending person:

Remove gloves, dispose and secure in a plastic bag.

Immediately apply soap. Thoroughly wash hands with soap by rubbing hands together (avoid scrubbing hands). Pay particular attention to fingertips, nails and jewelry. Rinse with fingers pointing downward.

If running water and soap are not immediately available, a waterless antiseptic cleaner or moist towelette may be used until hands can be thoroughly washed (use of antiseptic cleaner or towelette is NOT a substitute for handwashing). WASH HANDS AS SOON AS POSSIBLE.

[2] Centers for Disease Control and Prevention Guideline for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-care and Public Safety Workers. MMWR Vol. 38/No. S-6:1-37, 1989.

*** Body fluids that contain blood.** **** Non-latex gloves should be available for any staff member who has a known latex allergy.**



Supported by the Centers for Disease Control and Prevention: Cooperative Agreement U87/CCU822621-01

8/2003

# BLOODBORNE PATHOGENS SAMPLE EXPOSURE CONTROL PLAN

In accordance with the OSHA Bloodborne Pathogens standard, 29 CFR 1910.1030, the following exposure control plan has been developed:

## 1. Exposure Determination

OSHA requires employees to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. Exposure may be by one or more of the following routes: skin, eye, mucous membrane and parenteral contact. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this facility the following job classifications are in this category:

Job Classification

Sally Doe, School Nurse
Wye Nona, Principal
Hilary Mountain, Secretary - School Nurse Designee
Greg Outahere, Resource Room Teacher

Tasks/Procedures

1. Rendering medical care for school students, staff and visitors.
2. Cleaning and disposal of body fluids.

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be expected to incur exposure to blood or other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in these categories are considered to have occupational exposure. The job classifications and associated tasks for these categories are as follows:

1. School nurses who provide physical care in which blood is present (suctioning, first aid, immunizations, etc.).
2. Teachers and aides of students who have serious medical or behavior problems and require care that increases the risk of exposure to blood or serious secretions.
3. First aid providers. This may include physical education teachers, coaches and trainers.

# Guidelines for the Development of Bloodborne Pathogens Exposure Control Plan in a School District

An addendum to the sample plan. The numbers and page references are to the sample plan.

## 1. Exposure Determination

Through review of job requirements and past exposure experiences the district should determine those employees with reasonable expected exposure to blood and other potentially infectious materials in the performance of their regular duties. Exposure may be by one or more of the following routes: skin, eye, mucous membrane and parenteral contact.

Examples of occupational groups in schools may include:

1. School nurses who provide physical care in which blood is present (suctioning, first aid, immunizations etc.)
2. Teachers and aides of students who have serious medical or behavior problems and require care that increases the risk of exposure to blood or serious secretions.
3. First aid providers. This may include physical education teachers, coaches and trainers.
4. Custodians who clean and dispose of bloody wastes from classrooms and first aid rooms.

Individual job duties may be considered when determining those employees at risk.

Tasks and procedures in which occupational exposure may occur include: response to injury and/or illness, personal and or health care procedures and cleaning of blood waste.

In order to limit the number of employees with occupational exposure schools may want to designate first aid providers who will be assigned to high risk areas.

For workers whose exposure to blood is infrequent, timely post-exposure prophylaxis should be considered rather than routine pre-exposure vaccination. (MMWR November 22, 1991)

## 2. Implementation Schedule and Methodology

See attached - Sample: Universal Precautions in Schools

## 3. Annual training as outlined in the sample plan (pg. 7) requires for all employees determined to be at risk for occupational exposure.

Training which includes epidemiology and modes of transmission of bloodborne pathogens and general infection control procedures through universal precautions is recommenced for all employees.

**4. Hepatitis B vaccine, Post Exposure Procedures and Record Keeping**
See attached sample forms.

If employees incur exposure to their skin or mucous membranes then those areas shall be washed or flushed with water as appropriate as soon as feasible following contact.

**Needles**

Contaminated needles and other contaminated sharps will not be bent, recapped, removed, sheared or purposely broken. OSHA allows an exception to this if the procedure would require that the contaminated needle be recapped or removed and no alternative is feasible and the action is required by the medical procedure. If such action is required then the recapping or removal of the needle must be done by the use of a mechanical devise or a one-handed technique. At this facility recapping or removal is only permitted for the following procedure:

Use one-handed technique with repeating injection procedure.

**Containers for Reusable Sharps**

Contaminated sharps that are reusable are to be placed immediately, or as soon as possible, after use into appropriate sharps containers. At this facility the sharps containers are puncture resistant, labeled with a biohazard label, and are leak proof.

Sharps container located in nurse's room.

Container checked on weekly basis. Full containers will be taken to the Rutland Regional Medical Center Emergency Department for proper disposal. (See Appendix #2, Protocol)

**Work Area Restrictions**

In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke, or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets, or on countertops or bench tops where blood or other potentially infectious materials are present.

Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

All procedures will be conducted in a manner which will minimize splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials. Method which will be employed at this facility to accomplish this goal is:

Designated sink is located away from refrigerator and medicine cabinets.

## Specimens

Specimens of blood or other potentially infectious materials will be placed in a container which prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

The container used for this purpose will be labeled or color coded in accordance with the requirements of the OSHA standard.

Urine samples will be collected in plastic cups.

Any specimens which could puncture a primary container will be placed within a secondary container which is puncture resistant.

Plastic specimen cups placed in plastic bag in garbage receptacle for disposal.

If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

## Contaminated Equipment

Equipment which has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible.

N/A

## Personal Protective Equipment

All personal protective equipment used at this facility will be provided without cost to employees. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

Protective clothing will be provided to employees in the following manner:

Personal Protective Equipment

Protective eyewear (with solid side shield)
Surgical gown
Playtex utility gloves
Latex examination gloves

Protective gowns with profuse bleeding situation.

This facility will be cleaned and decontaminated according to the following schedule:

As needed.

Decontamination will be accomplished by utilizing the following materials:

1. 1-10 bleach solution; fresh daily supply.
2. Playtex gloves.

All contaminated work surfaces will be decontaminated after completion of procedures and immediately or as soon as feasible after any spill of blood or other potentially infectious materials, as well as the end of the work shift if the surface may have become contaminated since the last cleaning.
All bins, pails, cans, and similar receptacles shall be inspected and decontaminated on a regularly scheduled basis - weekly or as needed by school nurse or designee.

Any broken glassware which may be contaminated will not be picked up directly with the hands. The following procedure will be used:

Dust pan and broom.

**Regulated Waste Disposal**

All contaminated sharps shall be discarded as soon as feasible in sharps containers which are located in the facility. Sharps containers are located in the nurse's room.

Regulated waste other than sharps shall be placed in appropriate containers. Such are located in the nurse's room in a plastic-lined garbage receptacle.

**Laundry Procedures**

Laundry contaminated with blood or other potentially infectious materials will be handled as little as possible. Such laundry will be placed in appropriately marked bags at the location where it was used. Such laundry will not be sorted or rinsed in the areas of use.

All employees who handle contaminated laundry will utilize personal protective equipment to prevent contact with blood or other potentially infectious materials.

Laundry at this facility will be cleaned at the washer and dryer located in the school.

**Hepatitis B Vaccine**

All employees who have been identified as having exposure to blood or other potentially infectious materials will be offered the Hepatitis B vaccine, at no cost to the employee. The vaccine will be offered within 10 working days of their initial assignment to work involving the potential for occupational exposure to blood or other potentially infectious materials unless the employee has previously had the vaccine or who wishes to submit to antibody testing which shows the employee to have sufficient immunity.

See Appendix #3 and Appendix #4.

Employees who decline the hepatitis B vaccine will sign a waiver which uses the wording in Appendix A of the OSHA standard.

See Appendix #5

Employees who initially decline the vaccine but who later wish to have it may then have the vaccine provided at no cost.

Administrator and/or designee

**Post-Exposure Evaluation and Follow-Up**

When the employee incurs an exposure incident, it should be reported to the school nurse and administrator.

All employees who incur an exposure incident will be offered post exposure evaluation and follow-up in accordance with the OSHA standard.

This follow-up will include the following:

- Documentation of the route of exposure and the circumstances related to the incident.

- If possible, the identification of the source individual and, if possible, the status of the source individual. The blood of the source individual will be tested (after consent is obtained) for HIV/HBV infectivity.

- Results of testing of the source individual will be made available to the exposed employee with the exposed employee informed about the applicable laws and regulations concerning disclosure of the identify and infectivity of the source individual.

- The employee will be offered the option of having their blood collected for testing of the employees HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status. However, if the employee decides prior to that time that testing will or will not be conducted then the appropriate action can be taken and the blood sample discarded.

- The employee will be offered post exposure prophylaxis in accordance with the current recommendations of the U.S. Public Health Service. These recommendations are currently as follows:

1. Exposure site cleansing as necessary.
2. Referral to health facility.
3. Up-to-date tetanus status.
4. Hepatitis B vaccination series.
5. Gamma globulin injection will be given if the status of the source individual is known or suspicious of being Hepatitis B positive.
6. See Appendix #6.

- The employee will be given appropriate counseling concerning precautions to take during the period after the exposure incident. The employee will also be given

information on what potential illnesses to be alert for and to report any related experiences to appropriate personnel.

- The following person has been designated to assure that the policy outlined here is effectively carried out as well as to maintain records related to this policy:

  School nurse.

**Interaction with Health Care Professionals**

A written opinion shall be obtained from the health care professional who evaluates employees of this facility. Written opinions will be obtained in the following instances:

1. When the employee is sent to obtain the Hepatitis B vaccine.
2. Whenever the employee is sent to a health care professional following an exposure incident.

Health care professionals shall be instructed to limit their opinions to:

1. Whether the Hepatitis B vaccine is indicated and if the employee has received the vaccine, or for evaluation following an incident.
2. That the employee has been informed of the results of the evaluation.
3. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials.

See Appendix #7 and Appendix #8.

**Training**

Training for all employees will be conducted prior to initial assignment to tasks where occupational exposure may occur. Training will be conducted in the following manner:

Training for employees will include an explanation of:

1. The OSHA standard for Bloodborne Pathogens.
2. Epidemiology and symptomatology of bloodborne diseases.
3. Modes of transmission of bloodborne pathogens.
4. This Exposure Control Plan, i.e., points of the plan, lines of responsibility, how the plan will be implemented, etc.
5. Procedures which might cause exposure to blood or other potentially infectious materials at this facility.
6. Control methods which will be used at the facility to control exposure to blood or other potentially infectious materials.
7. Personal protective equipment available at this facility and who should be contacted concerning.
8. Post Exposure evaluation and follow-up.
9. Signs and labels used at the facility.
10. Hepatitis B vaccine program at the facility.

See Appendix #9.

## Recordkeeping

All records required by the OSHA standard will be maintained by the school nurse.

## Dates

All provisions required by the standard will be implemented by September 1992.

School nurse facilitator/trainer using as resources: public health, local health care professionals, VOSHA, Vermont Department of Health, Vermont Department of Education.

All employees will receive annual refresher training.

In-service at the beginning of each school year.

The outline for the training material is located in the nurse's room.

# CHILD ABUSE AND NEGLECT REPORTS

## STATEMENT OF PURPOSE:

School personnel are required by Vermont law to report suspected abuse or neglect to the Department for Children and Families (DCF). Suspected child abuse/neglect shall be reported within 24 hours.

## AUTHORIZATION/LEGAL REFERENCE:

33 V.S.A. Chapter 49, Child welfare services

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Follow Vermont law and school policy about reporting and documenting suspected abuse or neglect.
2. Document findings according to best practices. (See Documentation section)

## SUGGESTED SCHOOL NURSE ROLE:

Assist the administration in the development and implementation of the school abuse/neglect policies.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Become a member of the School or Community Child Protection Team.
2. Advocate and act as a resource for school faculty and other staff.

## RESOURCES:

- KidSafe Tool Kit For Reporting Child Abuse – www.kidsafevt.org
- U.S. Department of Health and Human Service-Administration for Children and Families http://nccanch.acf.hhs.gov
- Vermont Department for Children and Families - http://www.dcf.state.vt.us/

## SAMPLE POLICES, PROCEDURES, AND FORMS

Child Abuse Reporting Form

## VERMONT DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
## REPORT OF SUSPECTED CHILD ABUSE OR NEGLECT

| Child's Name: | Child's Address: | Age or Date of Birth: |
|---|---|---|
| Parents or other person responsible for child's care:<br>Name: | Address: | Relationship to child: |
| Was oral report made to SRS?<br>☐ Yes ☐ No | Reported by whom and when? | |
| Suspected Perpetrator's Name: | Address: | |
| Relationship to child: | Birthdate or approximate age: | |
| Name, address and phone number of other person having knowledge about alleged abuse: | | |

Explanation of the suspected abuse or neglect (including nature, extent, impact on child and evidence of previous abuse or neglect to the child or his/her siblings:

Are there siblings in the family? ☐ Yes ☐ No
Has the injury or problem been discussed with the family? ☐ Yes ☐ No
Is the family aware you are making this report? ☐ Yes ☐ No
Other information available: ☐ Medical exam ☐ Photographs ☐ Hospital Records ☐ X-Rays

### PERSON MAKING THIS REPORT

| Name: | Telephone: |
|---|---|
| Address: | Title or Relationship to child: |
| Signature: Date: | Agency: |

White copy for SRS, Yellow Copy for Reporter
SRS-305 R 2/00

# COMMUNICABLE DISEASES & NUISANCE CONDITIONS

## STATEMENT OF PURPOSE:

School personnel are required to report diseases of public health importance to the Vermont Department of Health.

## AUTHORIZATION/LEGAL REFERENCE:

- 18 V.S.A. Chapter 21 – Communicable diseases
- Vermont School Quality Standards, Section 2120.8.1.3.3

## DEFINITION:

**Communicable disease -** An infectious or contagious disease that can be transmitted from one person to another by direct physical contact, infected airborne droplets, etc.

**Nuisance condition** - Nuisance-type conditions include: Pediculosis (lice), Scabies and Ringworm.

**Reportable disease** – List of communicable disease defined by VDH that are required to be reported.

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLE:

Call VDH Reporting Line 1-888-588-7781, within 24 hours when you have reason to believe a student is sick or has died of a suspected reportable disease; identify the name and address of the student and the name and address of student's medical home. (See attached list of reportable diseases.)

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Be knowledgeable about current communicable disease regulations and control, current reportable diseases, and nuisance conditions. Maintain contact with local Vermont Department of Health.
2. Be knowledgeable about school policies and procedures related to communicable disease/nuisance condition prevention.
3. Act as a resource in the writing of school policies and procedures.
4. Refer to medical home for diagnosis. Exclude and readmit students suspected or demonstrated to have a communicable disease/nuisance conditions according to local school policies and procedures.
5. Collaborate with health care providers on limitations for the child upon return to school.
6. Promote prevention and control through in-service and serve as a resource person to staff.

7. Provide health counseling to parents and guardians regarding appropriate treatment and follow-up.
8. Notify school administrators in the event of a communicable disease/nuisance conditions outbreak and follow guidelines established by the Vermont Department of Health regarding information and protocols.
9. Document appropriate information in the student's record.

## SUGGESTED SCHOOL NURSE ROLES:

1. Promote prevention and control through health education.
2. Develop and write policies in collaboration for school administration.

## RESOURCES:

- Red Book: Report of the Committee on Infectious Diseases. (25th ed.). (2003). Elk Grove Village, IL: American Academy of Pediatrics.
- Vermont Department of Health School Liaisons
- Vermont Department of Health, Division of Epidemiology - http://www.healthyvermonters.info/hs/epi/idepi/reportable/reportable.shtml

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

- Vermont Department of Health Reportable Diseases
- Vermont Department of Health Head Lice Recommendations

# Vermont Department of Health
## Reportable Diseases

Health Surveillance Division

Updated 03/15/2004

**REPORTABLE:** Any unexpected pattern of cases, suspected cases, deaths or increased incidence of any other illness of major public health concern, because of the severity of illness or potential for epidemic spread, which may indicate a newly recognized infectious agent, an outbreak, epidemic, related public health hazard or act of bioterrorism.

AIDS
Amebiasis
Arboviral illness
Babesiosis
Campylobacter infection
*Chlamydia trachomatis* infection
Cholera
Creutzfeldt-Jakob disease/transmissible spongiform encephalopathies
Cryptosporidiosis
Diphtheria
Ehrlichiosis
Encephalitis
Enterococcal disease, vancomycin–resistant
Enterohemorrhagic *E.coli*, (including O157:H7)
Giardiasis
Gonorrhea
Guillain Barre syndrome
*Haemophilus influenzae* disease, invasive
Hantavirus disease
Hemolytic uremic syndrome (HUS)
Hepatitis A
Hepatitis B
Hepatitis B, positive surface antigen in a pregnant woman
Hepatitis C
Hepatitis, unspecified
Human immunodeficiency virus (HIV)*
*By Unique Identifier Code
Influenza
Lead poisoning
Legionellosis
Listeriosis
Lyme disease
Malaria
Measles (Rubeola)
Meningitis, bacterial
Meningococcal disease
Mumps
Pertussis (whooping cough)
Plague
Poliomyelitis
Psittacosis
Rabies, human and animal cases
Reye syndrome
Rheumatic fever
Rocky Mountain spotted fever
Rubella (German measles)
Rubella, congenital rubella syndrome
Salmonellosis
Severe Acute Respiratory Syndrome (SARS)
Shigellosis
*Streptococcus*, Group A invasive
*Streptococcus*, Group B invasive (infants less than one month of age)
*Streptococcus pneumoniae* disease, invasive
Syphilis
Tetanus
Toxic shock syndrome
Trichinosis
Tuberculosis
Typhoid fever
Varicella: (Chicken pox only)
- Persons 18 years of age or younger: aggregate weekly reporting OR individual case reporting
- Persons 19 years of age or older: individual case reporting

VRSA (vancomycin-resistant *Staphylococcus aureus*)/VISA (reduced susceptibility)
Vibrio species
Yellow fever
*Yersinia enterocolitica*

**Diseases which are possible indicators of bioterrorism:**

| | | |
|---|---|---|
| Anthrax | Brucellosis | Tularemia |
| Botulism | Smallpox | Viral hemorrhagic fever |

**Treatment:** Human rabies postexposure treatment (HRPET) is reportable even where no evidence of rabies has been found.

**Reporting of Diseases**

The law requires that health care providers report diseases of public health importance. Persons who are required to report: health care facilities, health care providers, health maintenance organizations, hospital administrators, laboratory directors, managed care organizations, nurse practitioners, nurses, physician assistants, physicians, school health officials, town health officers. Cases of reportable diseases should be reported to the Division within 24 hours.

**24 Hour Telephone Reporting Line (802)951-4080 or 1-888-588-7781**
**Consultation and Inquiries 802-863-7240 (7:45AM – 4:30PM M-F) or 1-800-640-4374 (VT only)**
**Emergency Consultation after normal business hours also available at numbers above**

**VERMONT DEPARTMENT OF HEALTH - Division of Community Public Health**
**1/31/05**
**RECOMMENDATIONS ON THE MANAGEMENT OF HEAD LICE**
**(PEDICULOSIS CAPITIS)**

## I. General Information on Head Lice

### A. Identification

Head lice (pediculosis capitis) are small wingless, crawling insects 2 to 3mm, about the size of a sesame seed that live on human scalp and hair as parasites. Adult lice live 6–27 days, laying about 10 eggs (nits) per day. These tiny eggs are firmly attached to the hair shaft close to the scalp with a glue like substance produced by the louse. Under optimum conditions (88$^{o}$ F), the eggs hatch in 10-14 days. The nymph grows for about 9-12 days, mate and the female lays eggs. Infestation by head lice occurs on the hair, eyebrows, and eyelashes. Infestations can result in severe itching, caused by the lice saliva, which in turn may lead to secondary infections. Head lice derive nutrients by bloodfeeding once or more often each day. They cannot survive for more than a day or so at room temperature without ready access to a person's blood. Light infestations (1–5 adult lice) may result in no symptoms. In at least 50% of infestations, no symptoms will be evident. Since adult lice tend to lay eggs close to the scalp, the duration of the infestation can often be estimated by the distance of the nit from the scalp. (1, 2, 4, 9, 10, 12)

Identification of the eggs, nymphs, and lice with the naked eye is possible, but is easiest with a hand lens and good light. Lice and their eggs are most often found at the nap of the neck and behind the ears. Diagnosis is usually made by identification of the nits which are tiny oval shaped opaque shells cemented to the hair shaft. They are difficult to dislodge and can be distinguished from hair casts or dandruff by their regular oval shape. Hatched eggs are snow white and conspicuous. Unhatched eggs are more difficult to see and may be tan or coffee colored. The lice themselves are less easily seen because they are tiny, fewer in number, and crawl rapidly away from light. (1, 2, 6, 7)

### B. Etiology:

Three species of lice infest humans: *Pediculus humanus capitis*, the head louse; *Pediculus humanus corpiris*, the body louse; and *Phthirus pubis*, the pubic or crab louse. Lice are host specific and those of lower animals (including pets) do not infest people. Head lice do not transmit any disease agents. The body louse has been involved in outbreaks of epidemic typhus, trench fever, and louse borne relapsing fever. (2, 3, 8)

In the U.S., infestations are less common in blacks than in individuals of other races. Children aged 3 to 12 years are more frequently infested than adults. All socioeconomic (12) groups are affected. Head lice are not able to fly or jump and they are unlikely to wander far from their preferred habitat. Lice and their eggs are unable to burrow into the scalp. Hair length does not influence infestation and having head lice is not a reflection of poor hygiene. Head lice infestation is not a major health hazard. It is, however, a nuisance which can often result in hardship for those involved including embarrassment, anxiety, physical discomfort and the expense of treatment, particularly when the entire household is affected. The greatest harm associated with head lice results from well intentioned but misguided use of caustic or toxic substances to eliminate the lice. (7, 11)

**C. Incubation Period:**

The life cycle is composed of three states: eggs, nymphs, and adults. Under optimal conditions, the eggs hatch in 10-14 days. The nymph stage lasts 9-12 days. The egg-to-egg cycle averages three weeks. Lice can be spread from person-to-person as long as lice remain alive on an infested person. Unhatched eggs cannot be spread from person-to-person until they hatch. [2, 4, 6, 7, 15]

**D. Modes of Transmission:**

1. Transmission occurs by direct contact with hair of infested individuals.
2. Head lice cannot jump or fly.
3. Lice can move very rapidly from one head to another when physical contact is made.
4. Shared objects such as hats or combs are possible modes of transmission, as are shared carpeting and bedding.
5. Household pets do not transmit lice.[2, 3, 6]
6. Head lice can survive less than 1day away from the host under normal conditions.[12]

## II. Treatment Recommendations

**A. Pediculicide Treatment**

1. Consult the primary care provider before applying lice treatment pesticides. This is especially important with some products if the individual is pregnant, breastfeeding, an infant, has allergies, asthma, or the lice or nits are in the eyebrows or eyelashes.
2. Check all family members for lice and nits. Only those persons infested should be treated.
3. Effective treatment involves the use of one of several pediculicides as a shampoo. Some pediculicides are available only by prescription; others are available over-the-counter.
4. No studies are presently available to substantiate the reliability of remedies such as herbal rinses, Vaseline and mayonnaise. Families should contact their family health care provider for advice on these forms of remedies.

**B. Non-Prescription (Over the Counter) Treatment Recommendations**

| | | |
|---|---|---|
| **Name Brand Names** | NIX** | RID; A-200; R+C; Pronto |
| **Generic** | 1% Permethrin | Pyrethins |
| **Application time** | 10 minutes (to dry hair) | 10 minutes (after shampooing) |
| **% Ovicidal** | 70–80% | 70 - 80% |
| **Beneficial Residual Activity** | Yes | No |
| **Adverse Properties** | None | Possible allergic reaction if sensitive to ragweed |
| **Resistance Reported** | Yes | Yes |

**Currently the recommended treatment of choice for head lice. [12, 5]

- All pediculicides are pesticides and must be used with caution.
- No product is 100% effective against lice.
- **Retreatment**: It is recommended that each infested person be retreated 7 to 10 days after the first treatment. Any eggs which survived the first treatment will have hatched by 10-14 days and will be killed by the second treatment before they are mature enough to lay more eggs.[3,7,12]

## C. Prescription Treatments

***Prescription treatment may be recommended when live lice are found after correct use of an over the counter product.***

1. **Malathion (Ovide)**

Malathion (Ovide), available by prescription, is a highly ovicidal lotion applied to the hair and left on for 8-12 hours before washing out. The major concerns are the high alcohol content, making it highly flammable, and the risk of severe respiratory depression if accidentally ingested. It also has an extremely disagreeable odor. Because of potential morbidity and even mortality possible with treatment, the risks and benefits must be carefully considered. It must be used with extreme caution and only in those cases where resistance to other products is strongly suspected. [12, 13]

2. **Lindane (Kwell)**

The Vermont Department of Health does not recommend the use of Lindane (formerly sold under the brand name Kwell). Lindane is available by prescription only. It should be used with extreme caution, if ever. It has the highest potential for toxic effects of all pediculicides, including central nervous system toxicity and seizures. [6, 7, 12, 16] Lindane is contraindicated in premature infants and in individuals with known seizure disorders. It should be used with extreme caution in children under 2 years of age, people with open or traumatized skin, and in pregnant or lactating women. Although it has low ovicidal activity, it may be indicated for people who have not responded or are intolerant of safer therapies.

*Carefully follow the directions provided by the manufacturer when using these products*

## D. Manual Removal

"Manual removal of nits after treatment with a pediculicide is not necessary because only live lice cause an infestation. Individuals may want to remove nits for aesthetic reasons or to decrease diagnostic confusion however, because none of the pediculicides are 100% effective, manual removal of nits (especially the ones within 1cm of the scalp) after treatment is recommended by some."[12] The following tips can add to successful removal:

- Work in natural or bright light, (a magnifying glass may be helpful).
- Use a nit-removal comb or your fingernails.
- Section hair, with special focus around ears and nape of neck.
- For children, plan to work in short periods and use a distraction such as music, a favorite show, or hand held toy.
- Check the head daily for 7 to 10 days after infestation
- A vinegar rinse can help to loosen nits. However, vinegar neutralizes the effectiveness of many pediculicides. Do not use a vinegar rinse after treatment and do not clean nit combs in vinegar.
- Successful vinegar rinse: use regular shampoo, rinse with vinegar, and then rinse out vinegar thoroughly **before** applying a pediculicide.
- Commercial products are advertised to dissolve the eggs or the cement by which the eggs are attached to the hair. To date, the effectiveness or safety of these products has not been determined. [10]

## E. Other Control Measures:

1. Lice can survive only up to 48 hours off the scalp[7]
2. All household members should be checked for head lice and only those with lice or nits within 1cm of the scalp or share a bed with the person infected should be treated.[13]
3. Spraying with pesticides is not recommended.
4. Clothing, bed linens, combs, brushes should be treated by washing in hot water (over 130°F for 20 minutes).[16]

5. Articles that cannot be laundered and have been in contact with the head of the person with the infestation 24-48 hours before treatment can be vacuumed or bagged and isolated for 10 days or dry cleaned.
6. Freezing articles for $72^{o}$ can kill lice and eggs.[11]

## III. Possible Resistant Head Lice

Parents and health professionals nationwide have reported treatment failures. [10] To date, national and Vermont entomologists suggest that the possibility of resistant lice needs to be studied further. They do indicate that when lice are exposed repeatedly to the same pediculicides, resistance could develop. No pediculicide is 100 % effective; thus, what may appear as resistant lice could be attributed to treatment failure. [1, 4, 8] Misdiagnosis, misuse, and noncompliance with follow-up treatment are typical problems. [13]

When treatment failure is suspected the family should contact their health care provider for further advice. A prescription treatment may be recommended.

## IV. Prevention Measures

It is probably impossible to totally prevent head lice. It is recommended for children to be taught not to share combs, brushes and hats. Prompt treatment can minimize the spread to others.

One of the most important tactics for controlling the spread of lice is in developing a prevention plan for the family, institutional setting, and community. Routine classroom or school-aide screening has not been shown to be an effective practice. [12] Public Health staff can be most effective by facilitating the development of a system-wide approach to controlling the communicable infestation of pediculosis capitis. An effective system approach to prevention of the spread of head lice needs to include the following:

**A.** **Identification of the at risk population** All socioeconomic groups are affected. Children in childcare and school age children are the most commonly affected by infestations.

**B.** **Identification of partners** Identify partners who can be important in a collaborative effort to educate, identify and control head lice infestations. The following are partners who should be considered: parents and children, school nurses and other school personnel, child care providers, primary care providers, town health officers, public health staff, community health clinics, community volunteers, civic groups, local media, business persons (e.g. drycleaners, Laundromats, pharmacies).

**C.** **Provide accurate and current information** Educate on etiology of lice, mode of transmission, treatment, control measures and other resources. Have all partners consider opportunities to educate such as health fairs, school open houses, staff training days.

**D. Facilitate the development of a collaborative plan for prevention of head lice and management of head lice outbreaks** Develop with individual institutions (e.g. childcare centers, schools) specific prevention measures that include the following:

1. Provide general information on identification of head lice during the first few weeks of each new school year, immediately following school breaks, or at least four times each year
2. Assign individual hooks/lockers in the school
3. Keep hats in coat sleeves
4. Permanently assign resting mats, towels or pillows and keep separate while in use or storage
5. Don't allow sharing of combs, brushes or hair ribbons
6. Limit home to school transporting of personal toys such as stuffed toys.
7. Assist schools and childcare facilities in setting a plan of action if head lice infestation occurs in more than 3 different students in the same class room or when 10% of the students in a classroom have evidence of infestation. (Refer to section on managing pediculosis humanus capitis infestation outbreak).
8. Send general fact sheet home at the beginning of the school year and at other key times (i.e. before school breaks). Send general fact sheet notification of outbreak (more than 3 students in a classroom or 10% of class) home with all students. Engage help of all parents to check for head lice weekly (sending home a fact sheet and notification every time one student in class has lice may become counterproductive and may tend to be ignored after awhile by parents. However, this may be an individual decision made by the school nurse to best suit the unique needs of each school).

## V. Managing Head Lice Outbreaks

### A. General Information

1. When a child is found to have head lice all household contacts and other children who were most likely to have direct head-to-head contact with the child should be checked.[12]
2. Those with live lice or nits within 1cm (1/2 inch) of the scalp should be treated
3. Parents should contact their primary care provider for recommended treatment.
4. Routine screening for lice has not been proven to have a significant effect on the incidence of head lice in schools.
5. Provide information to parents periodically on the diagnosis, treatment and prevention of head lice.
6. Due to the economic impact of head lice, treatment can be a hardship for families. Therefore, institutions may consider purchasing over the counter pediculicides in bulk to resell or providing it free for families in need.
7. Encourage parents to notify the school, childcare provider, and other close personal contacts when head lice have been identified.
8. Volunteers identified in advance can be helpful in the success of managing daily head checks.

### B. Management of the Day of Diagnosis

1. A child with an active head lice infestation poses little risk to others; therefore, the child should remain in class until the end of the school day, but be discouraged from close direct contact with others.[12]
2. Confidentially must be maintained so the child is not embarrassed.
3. Notify the child's parent by phone on the day that head lice are found or send home a note with the child at the end of the school day informing the parent(s) of the biology of head lice and methods to eliminate infestations and stating that prompt, proper treatment must be done before the child returns to school.
4. After treatment with a pediculicide (such as Nix or RID), removal of nits (more than 1cm away from the scalp) is not necessary to prevent spread because only live lice cause an infestation.

5. However, removal of nits may decrease diagnostic confusion, and the possibility of unnecessary treatment.
6. Consider sending a note out to parents of all children in the classroom, encouraging that children be checked at home and treated if appropriate before returning to school the next day.

## C. Criteria for Return to School

1. A child should be allowed to return to school after proper treatment.
2. A second application of a pediculicide may be needed 7 to 10 days after the first treatment. The parent(s) should notify their primary care provider for advice about prescription medications for recurrent infestations.
3. A child should not be prevented from returning to school because of the presence of nits.
   - "No Nit" policies requiring that children be free of nits before they return to childcare or school have not been effective in controlling head lice transmission and are not encouraged.[7]
   - "No Nit" policies disrupt the education process and should not be an essential strategy in management of head lice.[12]
   - The American Academy of Pediatricians and the National Association of School Nurses discourage "no nit" policies for return to school.[12, 14]
4. The school nurse should be available to re-check the child if requested by the parent and in cases of recurrent infestation.

## REFERENCES


1. Goddard, Jerome. Physician's Guide to Arthropods of Medical Importance. Boca Raton, FL: CRC Press, 1993 (3rd ed.).

2. Centers for Disease Control. "Fact Sheet: Treating Head Lice" www.cdc.gov. 2001

3. Chin, J. ed. Control of Communicable Disease Manual. American Public Health Association, 2000, (17th ed.).

4. Burger, J. "Detection, and Control of Human Lice"

5. The Medical Letter, "Drugs for Parasitic Infections" www.medicalletter.org. August 2004 pg. 6

6. National Pediculosis Association, "Overview of Lindane" www.headlice.org. June 30, 2002

7. American Academy of Pediatrics. "Report of the Committee on Infectious Disease." RedBook. 2003, (26th ed.). pg. 463-465

8. Kettle, DS. Medical and Veterinary Entomology. Wallingford, Oxon, U.K., C.A.B. International, 1990

9. National Pediculosis Association, "Resistant Lice? A Crisis for Kids" News Release November 20, 1995.

10. Pollack, Richard J. PhD. "Head lice information." Laboratory of Public Health Entomology, Harvard School of Public Health. http://www.hsph.harvard.edu/headlice.html. 9/9/2000

11. Williams, LK, Reichert, A., MacKenzie, WR, Hightower, AW, Blake, PA. "Lice, Nits and School Policy." Pediatrics. 2001; 107: 1011-1015.

12. Frankowski, BL., Weiner, LB. "The Committee on School Health; and the Committee on Infectious Diseases. Clinical Report: Head Lice." Pediatrics. 2002, 110: 638-643.

13. Burgess, Ian F., Pollack, Richard J., Taplin, David. "Cutting Through Controversy: Special Report on the Treatment of Head Lice." Premier Healthcare Resource. Morristown, NJ June 2003.

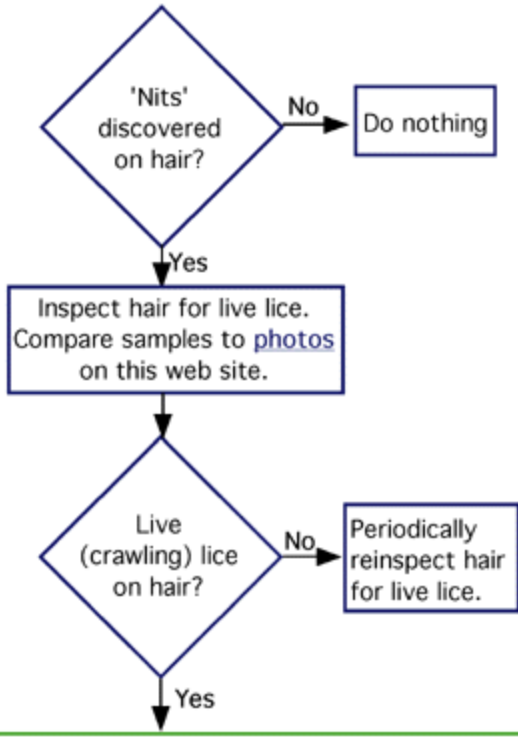
14. National Association of School Nurses. "Position Statement: Nit Free Policies in the Management of Pediculosis." November 1999.

15. Centers for Disease Control. "Parasites and Health: Head Lice." www.dpd.cdc.gov

16. Centers for Disease Control " Parasitic Disease Information, Fact Sheet: Treating Head Lice." www.cdc.gov

17. American Academy of Pediatrics. "Head Lice." Medical Library 2000 (excerpted from "Caring for your school age child: ages 5-12" Bantum 1999

## Scheme for managing presumed head louse infestations in schools





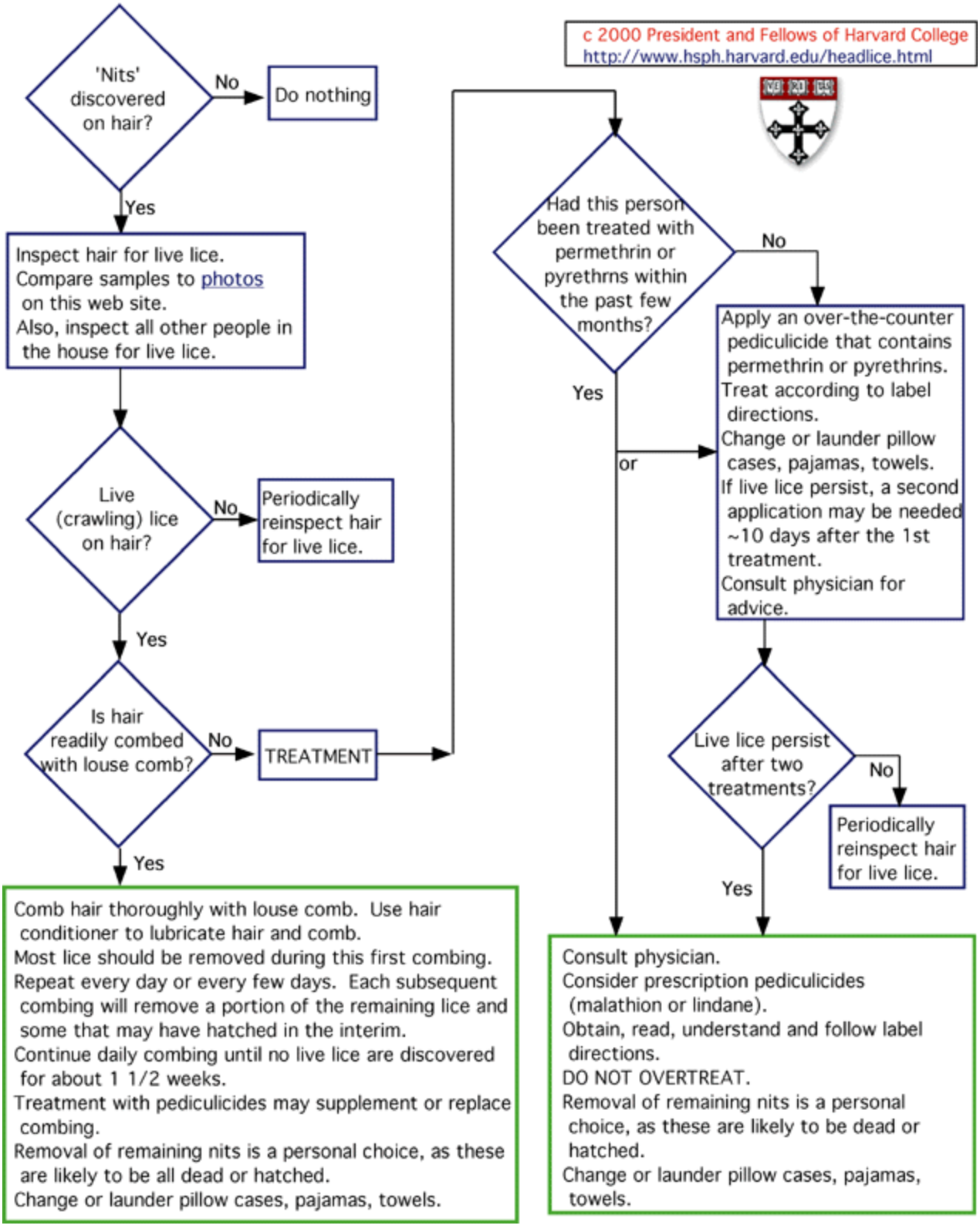

**RECOMMENDED RESPONSES** ✓

Notify parent/guardian at the end of the day of the suspected infestation.
Provide information on the biology of head lice and methods to eliminate infestations.

**UNJUSTIFIED RESPONSES** ✗

Exclusion or quarantine.
Notification of classmates' parents.
Mass screenings.
Insecticide treatments to school environment.
Reporting case to youth/social services.
Bagging of clothes.
Restricted use of headphones or athletic gear (helmets).

## Scheme for managing presumed head louse infestations



# CONFIDENTIALITY

Family Educational Rights and Privacy Act (FERPA)
Health Insurance Portability and Accountability Act (HIPPA)

## STATEMENT OF PURPOSE:

All school personnel should follow confidentiality practices required for student education and health records.

## AUTHORIZATION/LEGAL REFERENCES:

- 18 V.S.A. Chapter 21 § 1124 - Access to Records
- Secretary of Health & Human Services letter referencing FERPA and HIPAA relationship, September 1, 2004

## DEFINITIONS:

**Confidential Health Information** - personal, sensitive, information obtained most often by a health professional concerning the physical, developmental, or mental health of an individual.

**Duty to Warn** – a communication disclosing information to prevent danger to others or self.

**Legitimate Education Interest** - information conveyed to educational personnel that will directly benefit the student in their education setting.

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Establish and maintain a separate health record for each student.
2. Maintain records in a secure, locked (suggestion: fire proof cabinet) file.
3. Obtain written release of information form from parents/guardians regarding the sharing of information or obtaining information with professional resources outside of school for children under 18 years of age. Students who are 18 years of age are deemed independent and must grant consent for sharing of information.
4. Establish nursing protocol for sharing of health information that falls under the "duty to warn" parameters with education staff and volunteers.
5. Know your school district’s definition of "legitimate educational interest" and follow procedures when sharing health information with educational staff.
6. Establish with administration protocol for storing of sensitive records (i.e. psychiatric evaluations, child abuse reports, hospital reports).
7. Establish protocols around phone and electronically transmitted health sensitive information.
8. Establish protocols for disposition and storage of health records upon student's graduation.
9. Establish protocols maintaining confidentiality as it relates to other personnel, clinic assistants, and other unlicensed volunteers.

## RESOURCES:

Schwab, N.C., Gelfman, M.H.., *Legal Issues in School Health Services*, Sunrise River Press, 2001

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

- Confidentiality Best Practices
- Release of Information Form

# CONFIDENTIALITY BEST PRACTICES

1. The school health record is subject to Family Educational Rights to Privacy Act (FERPA) and should include only health data relevant to the student's educational needs. Parents may access their child's educational/health record. It is recommended that the nurse be present when the health record is reviewed to answer any health-related questions.

2. "Generally, school must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent to the following parties or under the following conditions (34 CFR §99.31):

    - School officials with legitimate educational interest;
    - Other schools to which a student is transferring;
    - Specified officials for audit or evaluation purposes;
    - Appropriate parties in connection with financial aid to a student;
    - Organizations conducting certain studies for or on behalf of the school;
    - Accrediting organizations;
    - To comply with a judicial order or lawfully issued subpoena;
    - Appropriate officials in cases of health and safety emergencies; and
    - Juvenile justice system, pursuant to specific State law."

3. Personal information belongs to the individual and his/her family and only they have a right to decide whether information should be disclosed to others. Confidential information (i.e. HIV results) should not be shared with staff (including administration), even with 'legitimate educational interest' unless there is the expressed written permission from the parent. (This information is not needed for the health/safety of the student and does not impact their education, nor does it impact the staff as universal precautions are practiced with all students.)

4. Parent and nurse together determine with whom health information can be shared based on "who needs to know" for the health and safety of the child.

5. All verbal or written requests for transferring or communication health information must include written permission from the parent or guardian.

6. Appropriate health personnel shall have access to student immunization records, when such access is required in the performance of official duties relating to immunizations.

7. Many school nurses keep sensitive health information in a separate personal record that is only for the nurse or the substitute nurse to access. (This record would be subject to disclosure to a parent under court order or subpoena.) Some nurses may choose not to keep a written record of sensitive information, but that practice does not follow the suggested Standards of Nursing Care in which documentation is stressed for best practice.

## Sample Authorization for Release of Medical Information

Date: _____

To: Primary Care Provider _____
(name & address)

_____

_____

From: Parent/Guardian _____

_____

_____

Please send information about my child _____ whose date

of birth is _____ to:

Health Services Office
Anywhere Elementary School
123 School Street
Anywhere, US 12345

Please send all pertinent information regarding _____

_____

Signature of
Parent/Guardian: _____

# COORDINATED SCHOOL HEALTH

## STATEMENT OF PURPOSE:

All schools should strive toward incorporating a coordinated school health approach to enhance student health outcomes and academic achievement.

## AUTHORIZATION/LEGAL REFERENCE:

16 V.S.A. Chapter 5 § 216 - Wellness program

## SUGGESTED SCHOOL NURSE ROLE:

Serve as the facilitator of a school health team.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLE:

Collaborate with administration/staff, students and community members to establish a coordinated school health approach.

## RESOURCES:

- Centers for Disease Control - http://www.cdc.gov/HealthyYouth/publications/infrastructure/
- Department of Health and Human Services, Stories From the Field, 2003
- Hoyle, T. The Mariner Model: Charting the Course for Health-Promoting Schools and Communities. Somerville, SC: Hoyle & Associates, 1996
- Marx, E., Wooley, S., Health is Academic. Teachers College Press, 1998
- School Health Index developed by CDC & available at: http://apps.nccd.cdc.gov/shi/HealthYouth/intro.htm
- Shirer, PhD, K., Promoting Healthy Youth, Schools and Communities: A Guide to Community-School Health Advisory Councils, American Cancer Society, 2003
- Vermont Department of Education - http://www.state.vt.us/educ/
- Vermont Department of Health – (802) 652-4178

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

- Vermont Coordinated School Health Model
- Critical Structures for Coordinated School Health

## Vermont Coordinated School Health Model

The Centers for Disease Control and Prevention promotes the establishment of a coordinated school health (CSH) approach in schools as the strategy necessary to improve students' health and thereby their capacity to learn. Education and health are indisputably linked. While schools cannot address all of children's health needs, their window of opportunity to prevent or reduce risky student health behaviors is vast. A coordinated and comprehensive approach targets key risk factors to health and learning; incorporates multiple strategies for prevention and education about health; gains support from students, parents, friends and adults within the community and employs a program planning process involving a wide variety of stakeholders. This is the key to success.

Vermont's Coordinated School Health model consists of nine components. A School Health Action Committee (SHAC) bolsters the implementation of these components and is a vital part of this model. The role of the SHAC is to identify, prioritize and plan for and implement action steps toward coordinating school health programs. Committee responsibilities may include, but are not limited, to:

- Program planning and implementation;
- Fiscal planning;
- Evaluating existing and new programs and services;
- Ensuring accountability and quality control;
- Assessing the health concerns and needs of students;
- Advocating for school health evaluation through visibility and sufficient resource allocation;
- Establishing and enhancing linkages with parents, families, community and local and state agencies.

The committee membership should represent a diverse cross section of the school community. Representation on the committee may include school staff, community health professionals, clergy, local business owners, parents, students, community agency staff members who are working with youth, law enforcement representatives and others interested in this initiative.

A coordinated school health approach reinforces positive healthy behaviors throughout the school community in several ways. For example, school nutrition services can serve appealing, nutritious foods that meet the USDA Dietary Guidelines, display informational materials that reinforce classroom lessons on nutrition and participate in the design of nutrition education programs. Students participating in youth programs can plan and implement school wide health initiatives that impact the school environment and staff and student wellness. Schools can offer parent education programs focusing on topics that parallel those in classroom curriculum. Physical education instructors can encourage lifelong physical activity by integrating instruction about health-related fitness throughout the year, including cardiovascular endurance, flexibility, muscular strength and endurance and body composition.

## Nine Components of Vermont's Coordinated School Health Model:

### 1. Promoting learning and adopting healthy behaviors

Health education provides children and youth the information and skills they need to make good choices in life. Students must have opportunities to integrate this knowledge, evaluate its relevance for themselves and apply these skills and behaviors within their school, home and community.

This component promotes:

- a planned, sequential, pre K-12 standards-based health education program that addresses the physical, mental, emotional and social dimensions of health;
- motivates and assists students to maintain and improve their health and reduce risky behaviors;
- access to valid health information;
- practice of health enhancing behaviors and reduction of health risks;
- ability to analyze the influence of culture, media, technology and other factors on health;
- use of interpersonal communication skills to enhance health;
- use of goal setting and decision-making skills;
- advocacy for personal, family and community health;
- integration of health instruction in other curriculum areas such as physical education, driver and traffic safety education, family and consumer sciences and developmental guidance; and
- an understanding of the human body and the impact of the environment on it.

### 2. Modeling and encouraging the achievement of life-long physical fitness

Physical activity on a regular basis will increase physical competence, health-related fitness, self-esteem and enjoyment. It improves one's muscular strength, flexibility, muscular endurance, body composition and cardiovascular endurance. Physical activity reduces tension and anxiety, strengthens peer relationships and reduces risk of chronic disease.

Participation in physical activity is associated with improved academic outcomes; maintenance of positive interpersonal relationships, increased concentration; improved mathematics, reading and writing assessment scores and reduced disruptive behaviors.

This component promotes:

- a physically active lifestyle;
- achievement and maintenance of a health-enhancing level of physical fitness;
- responsible personal and social behaviors in physical activity settings;
- opportunities for enjoyment, challenge, self-expression and social interaction;
- education about the benefits of life-long physical activity;
- environments which support physical activity opportunities for students, families and community members; and
- quality physical education programs within the school setting.

3. **Enhancing school health services**

School health services are essential to reduce learning barriers and to help prevent student health problems and injuries. Schools and communities must work together to ensure the availability of age-appropriate health services. Most often a full or part-time school nurse staffs the school health services program. In an effort to provide children and families with more accessible health care, some schools have expanded services to offer school-based health centers.

This component promotes:

- school-based health services to appraise, protect and promote health;
- access and referral to primary health care services;
- prevention and control of communicable disease and other health problems;
- emergency care for illness or injury;
- education and counseling opportunities for promoting and maintaining individual, family and community health; and
- collaborative efforts with parents and community health resources.

4. **Encouraging healthful nutrition**

Diet is linked to a number of physical health problems of childhood and adolescence, including obesity, anorexia, bulimia and dental caries. Children's brain function, and consequently school performance are diminished by even short-term or periodic hunger or malnutrition caused by skipping meals. Evidence shows that dietary behaviors tend to stay constant over time and poor eating habits established in childhood tend to persist through adulthood. Promoting healthy eating behaviors positively affects the health of students throughout their lives.

This component promotes:

- access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students and are consistent with U.S. Dietary Guidelines;
- access to culturally and medically appropriate foods that promote growth and development, pleasure in eating and long-term health;
- nutrition education programs that assist students in gaining the knowledge, attitudes and skills they need to develop healthy eating patterns;
- School Breakfast Program;
- including food service staff in developing classroom nutrition curricula; and
- making snacks that are of high nutritional value available to students.

5. **Supporting social and emotional well-being**

School counseling, psychological and social services are designed to prevent and address problems, facilitate positive learning and healthy behaviors and to enhance healthy development. Chronic emotional stress hinders the development of new networks within the brain associated with learning and memory. Even short-term stress can lead to neuron destruction and an inability to make clear judgments and distinguish between important and unimportant details. Establishment of comprehensive integrated approaches to addressing barriers to student learning and enhancing healthy development will lead to overall improvement of academic achievement.

This component promotes:

- accessible school counseling, social services and psychological and mental health services for all students;

- overcoming barriers to learning such as lack of food, clothing, housing and sense of security;
- prevent and address social and emotional problems that reduce students' ability to concentrate on academic pursuits;
- building the assets described in the Circle of Courage model (independence, belonging, generosity and mastery); and
- healthy psycho-social development**.**

6. **Creating Positive Learning Environments**

To learn and teach most effectively, students and staff must be in settings where they feel safe, supported and comfortable.

This component promotes:

- safe and aesthetically pleasing equipment, buildings and grounds;
- a culture that promotes an equitable, safe and healthy climate for all students; and
- policies, procedures, and conditions that support the well-being of students and staff.

7. **Promoting Faculty and Staff Wellness**

As staff pursue healthier lifestyles, morale and productivity will improve, absenteeism will decrease, health insurance costs will be reduced and students will benefit from an increased awareness of the importance of good health.

This component promotes:

- opportunities for fitness activities;
- health assessments;
- education and support programs;
- screening and early detection of health problems;
- education and supportive activities to reduce risk factors;
- organizational policies that promote a healthful and supportive worksite; and
- health care, insurance and related health support activities.

8. **Developing and supporting programs for children and youth**

After-school activity programs, mentoring programs and youth service projects provide children and youth the opportunity to expand their social skills, increase their self-confidence, be physically active, discover new areas of interest and to develop connections, strengthen their competence and provide opportunities for contributions at home and in the community. Academic and social outcomes have been shown to increase as a result of providing service to others.

This component promotes:

- supervised activities, such as athletics, clubs, peer leadership programs, and service learning that occur outside or within the curriculum; and
- youth programs focused on personal development, social responsibility, reasoning, problem-solving, and communication skills.

9. **Connecting school, parents and community**

Numerous reports and studies have found the amount of support from parents is the single most significant factor as to why some schools perform at higher levels of academic achievement. When families are involved in their children's education, children achieve higher grades, have better attendance, complete more homework, demonstrate more positive attitudes and behavior and graduate at higher rates.

This component promotes:

- school health action committees;
- coalitions, which build support for school health program efforts;
- involving parents; and
- creating partnerships among adults, community members and schools.

# Critical Structures for Coordinated School Health

**Purpose:** To increase the capacity of the school communities to help students grow up healthy and be successful learners.

## Health Coordinator (roles can be shared):

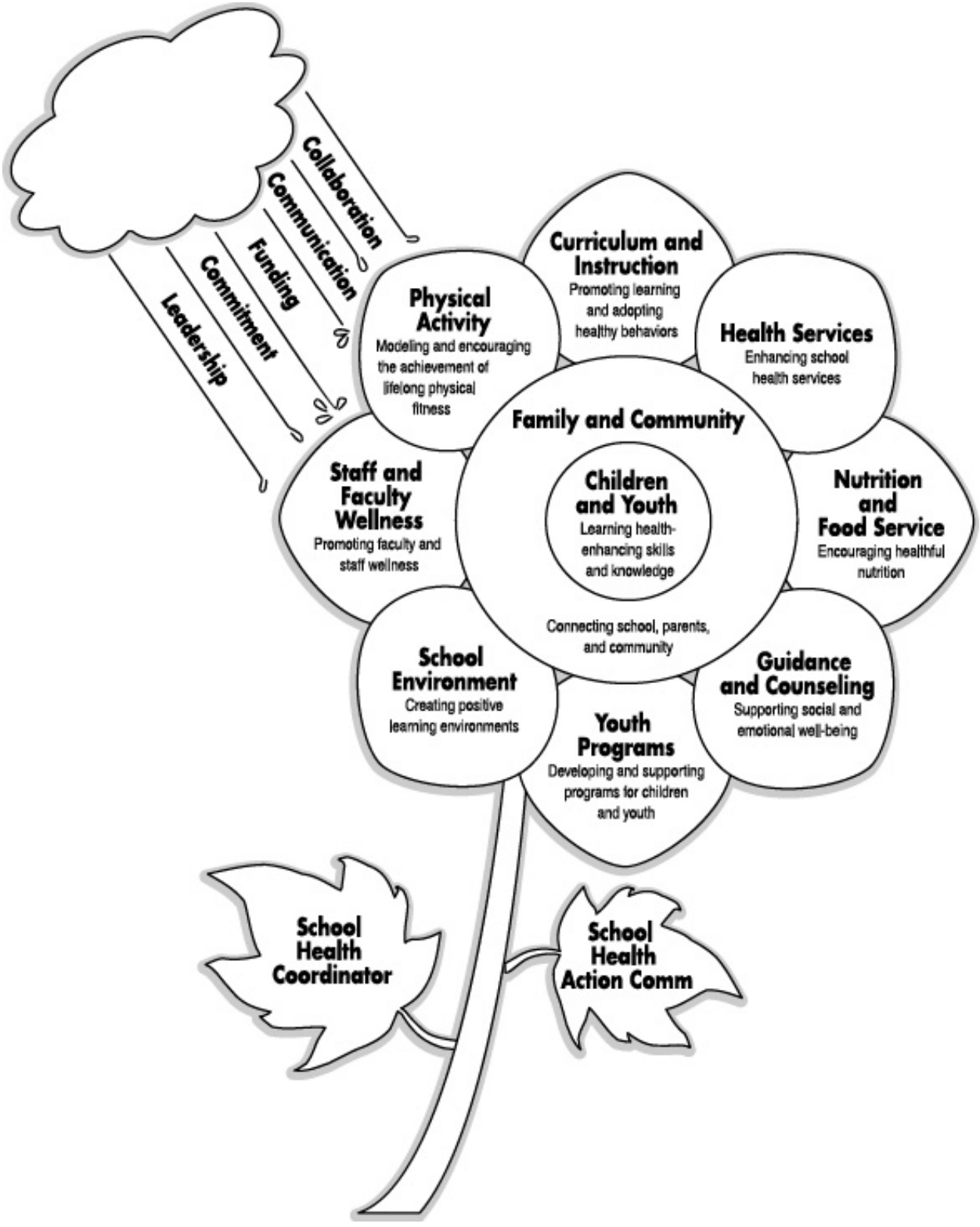
- Convenes, strengthens, supports, facilitates and institutionalizes the district health council/school committees
- Supports the development of local or school-based health facilitators and committees
- Recruits stakeholders
- Facilitates implementation of school health programs
- Engages and empowers others
- Advocates for Coordinated School Health

## District (Supervisory Union) Health Council:

- Develops vision, mission and goals for district-wide coordinated school health
- Develops district-wide plan for coordination of school health
- Assists with district policy development
- Supports local or school-based teams and their action plans
- Advocates for school health in the broader community
- Provides or arranges for district staff development
- Links local efforts with regional, state, and national organizations
- Assesses needs and evaluates progress
- Provides a forum for all schools' representation and community involvement

## School Health Action Committee(s)

- Develops vision, mission and goal and measurable objectives for coordinated school health
- Develops action plan for school-based initiatives
- Identifies existing and potential resources
- Monitors and evaluates action plan
- Coordinates activities with District Health Council
- Assesses needs
- Implements and evaluates progress
- Provides input and feedback regarding decisions of District Health Council
- Provides a forum for representation from staff, students, and community members


Collaboration
Communication
Funding
Commitment
Leadership
Curriculum and Instruction
Promoting learning and adopting healthy behaviors
Physical Activity
Modeling and encouraging the achievement of lifelong physical fitness
Health Services
Enhancing school health services
Family and Community
Children and Youth
Learning health-enhancing skills and knowledge
Staff and Faculty Wellness
Promoting faculty and staff wellness
Nutrition and Food Service
Encouraging healthful nutrition
Connecting school, parents, and community
School Environment
Creating positive learning environments
Guidance and Counseling
Supporting social and emotional well-being
Youth Programs
Developing and supporting programs for children and youth
School Health Coordinator
School Health Action Comm

# DELEGATION

## STATEMENT OF PURPOSE:

All schools should have a written policy regarding the delegation of health care activities. These procedures will be written by the registered nurse for unlicensed school personnel.

## AUTHORIZATION/LEGAL REFERENCE:

- 26 V.S.A. Chapter 28 § 1572(2) - Nurse Practice Act
- Vermont Department of Education and Vermont State Board of Nursing, Memorandum on Delegation of Authority to Administer Medications, April 14, 2000

## DEFINITIONS:

**Delegation -** transfer of responsibility for the performance of an activity from one individual to another, with the former retaining accountability for the outcome (School Nursing: Scope and Standards of Practice, 2005)

**Supervision -** active process of directing, guiding, and influencing the outcome of an individual's performance of an activity (School Nursing: Scope and Standards of Practice, 2005)

**Unlicensed Assistive Personnel -** individuals who are trained to function in the assistive role to the registered professional nurse in the provision of (student) care activities as delegated by and under the supervision of the registered professional nurse (School Nursing: Scope and Standards of Practice, 2005)

**Protocols** (nursing) - procedural statements written and used by nurses that outline the standard of practice for assessing and managing a specific clinical problem and authorize particular practice activities. Nursing protocols vary according to the level of education and licensure of the nurse(s) who will implement the protocol (Schwab, N. & Gelfman, D., 2001)

**Procedure -** a specific treatment (Schwab, N. & Gelfman, D., 2001)

**Policy -** any governing principle, plan, or course of action, in schools, general rules of procedures adopted by a local board of education (Schwab, N. & Gelfman, D. 2001).

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Maintain current guidelines for substitute nursing coverage. (see attached)
2. Determine activities to be delegated based on the nurse's assessment of:
   - the health status and stability of the student
   - the complexity of the task to be delegated
   - the training and competency of the designated person to whom the task is to be delegated

- the proximity and availability of the school nurse to the designated person when the selected nursing task will be performed
- the school's policies and procedures

3. Train LPNs and unlicensed assistive personnel and document successful demonstration of the delegated care.
4. Develop Individual Health Plan with written procedures.
5. Document ongoing review (include demonstration and evaluation of care) and supervision of LPNs and unlicensed assistive personnel and share with building supervisor for purpose of performance evaluations.
6. Document all nursing activities as performed in accordance with above roles.
7. Inform families about the system of delegation as appropriate.

**RESOURCES:**

- National Association of School Nurses – www.nasn.org
- National Council of State Board of Nursing Delegation: Concepts and Decision Making Tree - www.ncsbri.org
- Schwab, N. & Gelfman, M.H., Legal Issues in School Health Services, Sunrise River Press, 2001
- Standards of Professional School Nursing Practice, National Association of School Nurses, Inc., 1998.
- State of Vermont Administrative Rules: Board of Nursing, 1991.
- Vermont State School Nurses' Association – www.vssna.org
- Schwab, N & Haas, M. (February, 1995). Delegation ad Supervision in School Settings: Standards, Issues and Guidelines for Practice Part I. Journal of School Nursing. 11(1), 26-34.
- National Association of School Nurse Consultants. (April, 1995). Delegation of School Health Services to Unlicensed Assistive Personnel. Journal of School Nursing. 11(2), 17-19
- Panettieri, M.J. & Schwab, N. (April, 1996). Delegation ad Supervision in School Settings: Standards, Issues and Guidelines for Practice Part II. Journal of School Nursing. 12(2), 19-26.

**SAMPLE POLICIES, PROCEDURES, AND FORMS:**

- Guidelines for a Substitute School Nurse
- Joint Task Force for the Management of Children with Special Needs. (1990). Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting. Reston, VA: The Council for Exceptional Children.

# Guidelines for a Substitute School Nurse

**Qualifications:** A school nurse substitute must be currently licensed as a registered nurse. Other non-medical personnel may cover basic first aid and/or administer medication as delegated by the school nurse.

The school nurse shall prepare a manual or folder to be used by a substitute school nurse and the non-medical personnel.

The manual will provide the following:

1. The organizational chart of the school showing line of responsibility
2. List of administration, staff and teachers
3. List of resource nurses available in the region and telephone numbers
4. Layout of the school
5. Responsibilities for the substitute
6. School policies related to health and emergency protocols
7. Class rosters with teacher's names and classroom locations
8. List of students
    a. With special health needs
    b. On daily medication (i.e. name, dosage, time)
    c. With life-threatening allergies
9. Location of IHP's, protocols and procedures
10. Important telephone numbers
11. Process for notifying parents and sending sick students home
12. Daily visit log/student files/emergency phone numbers for students
13. Location of supplies (i.e. first aid, epinephrine, medications)
14. Location of Vermont Standards of Practice: School Health Services Manual

## GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

| PROCEDURE | PHYSICIAN ORDER REQUIRED | REGISTERED NURSE (RN) | LICENSED PRACTICAL NURSE (LPN) | CERTIFIED TEACHING PERSONNEL | RELATED SERVICES PERSONNEL[1] | PARA PROFESSIONALS[2] | OTHERS[3] |
|---|---|---|---|---|---|---|---|
| **1.0 ACTIVITIES OF DAILY LIVING** | | | | | | | |
| 1.1 Toileting/Diapering | | A | A | A | A | (A) | A |
| 1.2 Bowel/Bladder Training (Toilet Training) | | A | A | (A) | A | S | S |
| 1.3 Dental Hygiene | | A | A | A | A | S | S |
| 1.4 Oral Hygiene | | A | A | (A) | A | S | S |
| 1.5 Lifting/Positioning | | A | A | (A) | A | S | S |
| 1.6 Feeding | | | | | | | |
| 1.6.1 Nutrition Assessment | | A | X | X | N | X | X |
| 1.6.2 Oral-Motor Assessment | | X | X | X | (SP/TH) | X | X |
| 1.6.3 Oral Feeding | | A | A | A | A | (S) | S |
| 1.6.4 Naso-Gastric Feeding | * | (A) | (S) | X | X | (S/HA) | X |
| 1.6.5 Monitoring of Naso-Gastric Feeding | | A | S | S | S | S | X |
| 1.6.6 Gastrostomy Feeding | * | (A) | (S) | X | X | (S/HA) | X |
| 1.6.7 Monitoring of Gastrostomy Feeding | | A | S | S | S | S | X |
| 1.6.8 Jejunostomy Tube Feeding | * | (A) | (S) | X | X | X | X |
| 1.6.9 Total Parenteral Feeding (Intravenous) | * | (A) | (S) | X | X | X | X |
| 1.6.10 Monitoring of Parenteral Feeding | | A | S | S | S | S | X |

DEFINITION OF SYMBOLS

A Qualified to perform task, not in conflict with professional standards
S Qualified to perform task with RN supervision and inservice education
EM In emergencies, if properly trained, and if designated professional is not available
X Should not perform
N Nutritionist only
TH Occupational or physical therapist only
SP Speech/language Pathologist only
HA Health Aide only
(○) Person who should be designated to perform task

1 Related Services include N, TH, and SP.
2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.
3 Others include secretaries, bus drivers, cafeteria workers, custodians.

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|---|---|---|---|---|---|---|---|
| 1.6.11 Naso-Gastric Tube Insertion | * | (A) | (S) | X | X | X | X |
| 1.6.12 Naso-Gastric Tube Removal | * | (A) | (S) | EM | EM | EM/HA | X |
| 1.6.13 Gastrostomy Tube Reinsertion | * | (A) | (S) | X | X | X | X |
| **2.0 CATHETERIZATION** | | | | | | | |
| 2.1 Clean Intermittent Catheterization | * | (A) | (S) | X | X | S/HA | X |
| 2.2 Sterile Catheterization | * | (A) | (S) | X | X | X | X |
| 2.3 Crede | * | A | S | S | S | (S/HA) | S |
| 2.4 External Catheter | * | (A) | (A) | S | S | (S/HA) | X |
| 2.5 Care of Indwelling Catheter (Not Irrigation) | * | (A) | (S) | S | S | (S/HA) | X |
| **3.0 MEDICAL SUPPORT SYSTEMS** | | | | | | | |
| 3.1 Ventricular Peritoneal Shunt | | | | | | | |
| 3.1.1 Pumping | * | (EM) | (EM) | X | X | X | X |
| 3.1.2 Monitoring | * | (A) | S | S | S | S | X |
| 3.2 Mechanical Ventilator | | | | | | | |
| 3.2.1 Monitoring | * | (A) | (S) | EM | EM | S/HA | X |
| 3.2.2 Adjustment of Ventilator | * | X | X | X | X | X | X |
| 3.2.3 Equipment Failure | * | (A) | (S) | EM | EM | EM | EM |

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|---|---|---|---|---|---|---|---|
| 3.3 Oxygen | | | | | | | |
| 3.3.1 Intermittent | * | (A) | (S) | EM | EM | EM | X |
| 3.3.2 Continuous (Monitoring) | * | A | S | S | S | S | S |
| 3.4 Hickman/Broviac/IVAC/IMED | * | (A) | (S) | X | X | X | X |
| 3.5 Peritoneal Dialysis | * | (A) | (S) | X | X | X | X |
| 3.6 Apnea Monitor | * | A | S | S | S | S/HA | X |
| **4.0 MEDICATIONS** | | | | | | | |
| **Medications may be given by LPN's and Health Aides only where the Nurse Practice Act of the individual state allows such practice, and under the specific guidelines of that nurse practice act.** | | | | | | | |
| 4.1 Oral | * | (A) | (S) | X | X | S/HA | X |
| 4.2 Injection | * | (A) | (S) | X | X | X | X |
| 4.3 Epi-Pen Allergy Kit | * | (A) | (S) | EM | EM | EM | EM |
| 4.4 Inhalation | * | (A) | (S) | EM | EM | EM/HA | EM |
| 4.5 Rectal | * | (A) | (S) | X | X | EM/HA | X |
| 4.6 Bladder Installation | * | (A) | (S) | X | X | X | X |
| 4.7 Eye/Ear Drops | * | (A) | (S) | X | X | S/HA | X |

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|---|---|---|---|---|---|---|---|
| 4.8 Topical | * | (A) | (S) | X | X | S/HA | X |
| 4.9 Per Nasogastric Tube | * | (A) | (S) | X | X | S/HA | X |
| 4.10 Per Gastrostomy Tube | * | (A) | (S) | X | X | S/HA | X |
| 4.11 Intravenous | * | (A) | (S) | X | X | X | X |
| 4.12 Spirometer | * | (A) | (S) | X | X | S/HA | X |
| **5.0 OSTOMIES** | | | | | | | |
| 5.1 Ostomy Care | * | (A) | (S) | EM | EM | EM | X |
| 5.2 Ostomy Irrigation | * | (A) | (S) | X | X | X | X |
| **6.0 RESPIRATORY ASSISTANCE** | | | | | | | |
| 6.1 Postural Drainage | * | (A) | (S) | S | S | S/HA | S |
| 6.2 Percussion | * | (A) | (S) | S | TH | S/HA | S |
| 6.3 Suctioning | | | | | | | |
| 6.3.1 Pharyngeal | * | (A) | (S) | S | S | S/HA | X |
| 6.3.2 Tracheostomy | * | (A) | (S) | S | S | S/HA | X |
| 6.4 Tracheostomy Tube Replacement | * | (EM) | (EM) | EM | EM | EM | EM |
| 6.5 Tracheostomy Care (Cleaning) | * | (A) | (S) | X | X | X | X |

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|---|---|---|---|---|---|---|---|---|
| **7.0** | **SCREENINGS** | | | | | | | |
| 7.1 | Growth | | (A) | (S) | S | S | S | X |
| 7.2 | Vital Signs | | (A) | (S) | X | X | S/HA | X |
| 7.3 | Hearing | | (A) | (S) | X | (SP) | S/HA | X |
| 7.4 | Vision | | (A) | (S) | X | X | S/HA | X |
| 7.5 | Scoliosis | | (A) | (S) | S | TH | S/HA | X |
| **8.0** | **SPECIMEN COLLECTING/TESTING** | | | | | | | |
| 8.1 | Blood Glucose | * | (A) | (S) | X | X | S/HA | X |
| 8.2 | Urine Glucose | * | (A) | (S) | X | X | S/HA | X |
| **9.0** | **OTHER HEALTH CARE PROCEDURES** | | | | | | | |
| 9.1 | Seizure Procedures | | A | A | A | A | A | A |
| 9.2 | Soaks | * | (A) | (S) | X | TH | S/HA | X |
| 9.3 | Dressings, Sterile | * | (A) | S | X | X | X | X |

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|---|---|---|---|---|---|---|---|---|
| 10.0 | DEVELOPMENT OF PROTOCOLS | | | | | | | |
| 10.1 | Health Care Procedures | | (A) | X | X | X | X | X |
| 10.2 | Emergency Protocols | | (A) | (WITH PHYSICIAN CONSULTATION) | | | | |
| 10.3 | Individual Education Plan Health Objectives | | (A) | X | X | X | X | X |
| 10.4 | Nursing Care Plan | | (A) | X | X | X | X | X |

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# DOCUMENTATION

## STATEMENT OF PURPOSE:

Student and staff health information is documented according to recommended nursing principles of documentation.

## AUTHORIZATION/LEGAL REFERENCE:

- 18 V.S.A. Chapter 21 § 1124 - Access to Records
- 26 V.S.A. Chapter 28 § 1572(2) - Nurse Practice Act
- Secretary of Health & Human Services letter referencing FERPA and HIPAA relationship, September 1, 2004
- Vermont Department of Education Memorandum on Retention of Immunization Records, October 15, 2002

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Document subjective and objective data, nursing assessment, interventions and plans in the student's health record or staff record.
2. Use the recommended principles of nursing documentation. (See attachment)
3. Maintain individual health records (See Confidentiality section) which may include:
    - Health assessments
    - School exams or screening; psychological reports according to school policy
    - Specific procedures and documentation of administering medication
    - Record of injuries and illnesses
    - Reports of abuse
    - Individual health plans
    - Release of information
    - 504 plan
    - Correspondence with other agencies
    - Documentation of training of delegated procedures
4. Maintain other documentation related to school health services
    - Accident reports
    - Medical incident reports
    - Annual immunization reports
    - Annual Department of Education screening reports
    - Staff delegation
    - Staff records
    - Emergency information
    - Supervision of staff
    - Reports of abuse
    - Correspondence with other agencies/health care providers
5. Follow Vermont policy and procedures for education records. (see attachment)

**RESOURCES**:


- HIPPA and Schools, School Health Alert, Nashville, TN, Special supplement, October 2003.
- National Association of School Nurses - www.nasn.org
- Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, p.311, Sunrise River Press, 2001


**SAMPLE POLICIES, PROCEDURES AND FORMS:**

- Nurses Principles of Documentation
- Errors in Documentation
- Reportable incidents
- Length of Time to Hold Records

## Nursing Principles of Documentation

Nursing documentation should be accurate, objective, concise, thorough, timely, and well organized.

1. All entries should be legible and written in ink.
2. Computerized records must be secure and password protected.
3. The date and exact time should be included with each entry.
4. Documentation should include any nursing action taken in response to a student's problem.
5. Assessment data should include significant findings, both positive and negative.
6. All records, progress notes, individualized health care plans, and flow charts should be kept current.
7. Documentation should include only essential information; precise measurements, correct spelling and standard abbreviations should be used.
8. School nursing documentation should be based on nursing classification and include uniform data sets.
9. The frequency of documentation should be consistent over time and based on district policy, nursing protocols and the acuity of the student's health status.
10. Standardized health care plans increase efficiency of documentation and are acceptable to use so long as they are adapted to the individual needs of each student.
11. Student symptoms, concerns, and health maintenance questions (subjective data) should be documented in the student's own words.
12. Only facts (objective data) relevant to the student's care and clinical nursing judgments based on such facts should be recorded; personal judgments and opinions of the nurse should be omitted. For example, 'the students is breathing normally' is an opinion, whereas the notation 'respirations 20/min.; no retractions, rales or wheezing" provides objective data.'

**(Reference:** Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, Sunrise River Press, 2001)

## Errors in Documentation

1. References to district problems, including staffing shortages, should never be included in student records.
2. Terms suggestive of an error should not be used, for example, “accidentally” or “by mistake”; state only the facts of what occurred.
3. When an error is made, one single line should be drawn through the error; the word “error” and the nurse’s signatures should be written directly above it. The correct entry should then follow. Words should never be erased or scratched or whited out.
4. When an entry is made in the wrong student’s record, the entry should be marked “mistake in entry,” and a line drawn through the mistaken entry, as above.
5. Late entries should be avoided. When necessary, a late entry may be added, but in the correct date and time sequence. (For example, write today’s date and time when entering a note related to care provided yesterday afternoon and mark it “late entry”.

## Reportable Incidents

Reportable incidents that result in injury or potential injury should be documented. These include but are not limited to:

1. Injury requiring or probably requiring a physician’s or dentist’s care;
2. Injury referred by the nurse for medical evaluation;
3. Injury requiring major first aid;
4. Injury which has the potential for litigation; and
5. Failure to administer prescribed medication within the appropriate timeframe, in the correct dosage, or to the correct student.

## Actions to be taken

1. Incident/Accident reports or medication error reports are completed as soon as possible within 24 hours of the occurrence;
2. Parents are notified;
3. Administration is notified immediately or in a timely manner;
4. Documentation in the student log reflects the facts of the incident and steps taken to rectify the situation;
5. Follow-up is completed and documented within 24-48 hours as needed; and
6. Copies of the report are filed in the Principal’s and/or Health Office, separate from the student’s record and intended for internal use/analysis.

**Reference:** Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, Sunrise River Press, 2001

## Length of Time to Hold Records

Health records are treated like any other student record under federal and state laws. In Vermont, academic records including health records are held at least five years after a student leaves the school.

**Reference:** Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: Legal Issues in School Health Services, Sunrise River Press, 2001

# DRUG, ALCOHOL AND TOBACCO USE

## STATEMENT OF PURPOSE:

All schools shall have a drug, alcohol and tobacco policy consistent with the State Board of Education guidelines.

## AUTHORIZATION/LEGAL REFFERENCE:

- 16 V.S.A. Chapter 25 § 1165 – Alcohol and drug abuse
- State Board of Education Manual of Rules and Practice, Section 4212 - 4215 – Act 51
- Vermont School Quality Standards, Section 2120.8.2.3

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Be knowledgeable about the signs and symptoms of substance use, the substances available and the prevalence of use in the community.
2. Collaborate with the school's administration to create a policy regarding alcohol, tobacco or other drugs (ATOD).
3. Collaborate with the school's administration to create a referral procedure for students who are suspected of being under the influence of ATODs while on school grounds or for students who display a preoccupation with ATODs.
4. Educate the faculty and staff about the school's referral procedure and signs and symptoms of substance use.
5. Collaborate with the school's administration and student assistance counselors to develop a substance use assessment form.
6. Conduct substance use assessments for students who are referred to the health office to determine if it is safe for the student to remain in school.
7. Become an advisor for a student prevention group.
8. Be a resource for students and parents regarding ATODs; provide pamphlets, displays, bulletin boards and smoking cessation groups.
9. Educate parents about the use of substances in your school's newsletter.

## RESOURCES:

- Provider's Toolkit; VDH; Health Screening for Children & Adolescents
- School Health: Policy and Practice, 6th edition by the American Academy of Pediatrics, Committee on School Health, 2004
- Vermont Department of Health - http://www.state.vt.us/adap/

## SAMPLE POLICIES, PROCEDURES, AND FORMS

Vermont School Board Sample Policies

- Alcohol and Drugs
- Substance Abuse Incidents
- Tobacco Prohibition

# VERMONT SCHOOL BOARD ALCOHOL AND DRUGS SAMPLE POLICY

## Policy

It is the policy of this School District that no student shall knowingly possess, use, sell, give or otherwise transmit, or be under the influence of any illegal drug, regulated substance, or alcohol on any school property, or at any school-sponsored activity away from or within the school.

## Philosophy

This policy is concerned with the health and well-being of all students and the policy takes into consideration the individual needs of students with alcohol and substance abuse problems as well as the right of all students to receive an appropriate education in an alcohol and drug-free environment. The Board encourages educational programs that provide every student with an understanding of the physical, psychological, social and legal dangers associated with drug abuse.

Chemical abuse and dependency are treatable health problems that are primarily the responsibility of the home and the community. The school shares this responsibility in the areas of prevention (education) and intervention (identification and referral).

Community and schools share in this responsibility because chemical problems often interfere with behavior, learning, and the fullest possible development of each student.

## Definitions

***Alcohol and drug (substance) abuse*** is the ingestion of a substance in such a way that it interferes with a person's ability to perform physically, intellectually, emotionally, or socially.

***Drug*** means any narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana or any other controlled substance as defined by state or federal regulation or statute.

## Implementation

The Superintendent (or designee) is responsible for implementing procedures to see that the following requirements are met:

1. **Educational Program.** The District shall conduct an alcohol and drug abuse educational program on a sequential basis from early childhood through grade 12 in accordance with the mandates of 16 V.S.A. §909, the Vermont Alcohol and Drug Education Curriculum Plan, and the federal Safe and Drug-Free Schools and Communities Act (20 U.S.C. §§1701 et seq.).

2. **Cooperative Agreements.** In dealing with substance abuse cases, every effort will be made to promote responsible decision-making by the student involved and other students who are aware of another student's use or abuse. The focus will be to encourage appropriate medical and/or psychological intervention by trained professionals. Students and parents or guardians will be given information about outside agencies and will be encouraged to take advantage of their services and programs.

The _____School District, under a cooperative agreement with _____ [AGENCY] _____, has established a Student Assistance Program. Students, under the age of eighteen, who have been referred or who refer themselves to the Student Assistance Program counselor may be seen individually by the counselor for purposes of substance abuse screening and consultation. It will be the goal of the Student Assistance Program to encourage the student to involve his/her parents or guardians at the earliest point in time.

No student under the age of 18 will be referred to an outside agency for substance abuse treatment without parental consent unless, in accord with 18 V.S.A. §4226, the student is 12 or over and found by a licensed physician to be dependent upon regulated drugs or an alcoholic.

Parental consent is not required for student participation in group programs conducted within the schools which are educational in nature and designed to impart information and/or assist students in improving their sense of self-esteem. Such groups may be conducted only by trained professionals contracted by the schools to perform such service or by trained school staff who have been approved by the school administration to conduct such groups.

1. **Substance Abuse Team.** In each school the Principal shall form a Substance Abuse Team which shall screen students who refer themselves and students who are referred by staff for suspected drug and/or alcohol use and/or abuse problems. The membership of the team and the procedures to be used by the team will be developed by the Principal and disseminated in writing to the building faculty and staff.

2. **Staff Training.** The District will provide school staff with training such that teachers and health and guidance personnel can competently teach or provide other services required in the school's alcohol and drug abuse prevention education program. Such training is outlined in State Board Rule 4213.2.

3. **Community Involvement.** The District will provide for a program to inform the community about substance abuse issues and about how schools are handling such issues.

4. **Annual Report.** In a standard format provided by the Department of Education, schools will submit an annual report to the Commissioner of Education describing substance abuse education programs and their effectiveness.

5. **Notification.** Parents and students will be given a copy of the standards of conduct and disciplinary sanctions contained in this policy and accompanying procedures, and will be notified that compliance with the standards of conduct is mandatory.

# VERMONT SCHOOL BOARD SUBSTANCE ABUSE INCIDENTS SAMPLE POLICY

Students who are experiencing problems with alcohol and drugs are in need of assistance. The type of assistance needed may vary; however, the school system is committed to providing the most appropriate response to each individual. The actions set forth below will be considered routine procedures. In situations where extreme violations occur, the specific action may be waived by the administrator. Any action taken by waiver of these procedures will be explained in a written report to the Superintendent. All disciplinary measures taken in accordance with this policy will comply with due process requirements and, where appropriate, will be consistent with the rights of students with disabilities as reflected in the school's discipline policy.

**Students under the influence of alcohol and/or drugs**

1. **First Offense**

    a. A student will be treated as an ill student and will be sent home by an administrator after the parents have been notified. In crisis situations the matter will be handled as a medical emergency and accordingly the school officials will involve ambulance and police assistance as may be appropriate.

    b. Upon the return to school the following day, the student will be dealt with in accordance with the school's discipline program, if applicable.

    c. Police shall be notified when drugs are involved. Reporting of 1st offense alcohol problems to the police is within the discretion of the administrator.

    d. The student will be referred to the school's Substance Abuse Team.

2. **Second offense**

    a. Steps (a, b and d) of the 1st offense procedures.

    b. Police shall be notified regardless of whether the offense is drug or alcohol related.

    c. The student will undergo an alcohol/drug assessment within ten days of the incident and will participate in a treatment program if warranted by the assessment.

    d. Failure to comply with (c) above (will / may) result in the student being suspended from school for ten days.

3. **Third Offense**

    a. Step (a) of the 1st offense procedures...

    b. Police shall be notified.

    c. The student (will / may) be suspended from school for ten days and may be recommended to the Board for long-term suspension or expulsion.

**Students in possession of drugs, drug paraphernalia, and/or alcohol**
When students are found in possession of drugs, drug paraphernalia, and/or alcohol, the substance(s) will be removed from the student. Procedures for handling such incidents will be identical to those used when a student is found to be under the influence of drugs and/or alcohol, except for Step 1a.

**Students selling or furnishing alcohol and/or drugs**

1. **First offense**

    a. The student will be suspended from school for ten days after the parents have been notified.

    b. Police shall be notified.

    c. The student will be referred to the school's Substance Abuse Team.

1. **Second offense**

    a. Steps (a) and (b) for 1st offense will be followed.

    b. The student may be recommended to the Board for long-term suspension or expulsion.

**Suspected Substance Abuse**
When a staff member has reason to believe that a student might be having a problem related to substance abuse, the staff member shall make a referral to the Substance Abuse Team.

**Co-Curricular Activities**
Students who violate the School District's policy on alcohol and drugs while they are members of a school team, are subject to additional disciplinary actions as are defined in the school's training rules. Any student who commits a second offense, in the same year, of the School District's policy may not represent the school and consequently the student will immediately be dismissed from all co-curricular activities (athletic and non-athletic) for the remainder of the school year.

# VERMONT SCHOOL BOARD TOBACCO PROHIBITION SAMPLE POLICY

## Policy

It is the policy of the _____School District to prohibit the use of tobacco on school grounds in accordance with state law. This ban extends to any student, employee or visitor to the school, and applies at all times, whether or not school is in session. Students are, furthermore, prohibited from possessing tobacco products at all times while under the supervision of school staff or at school sponsored activities.

## Administrative Responsibility

The Superintendent or his or her designee is directed to take reasonable steps to inform students and employees of this policy, to post signs on school property and to provide notice to visitors and those who are invited to attend school activities in bulletins, programs and announcements related to school events.

**Violations of Policy** Students who violate this policy will be disciplined under the school's disciplinary policy and procedures, and tobacco products may be confiscated.

Employees who violate this policy will be subject to disciplinary action in accord with applicable employee policies, employment contracts and requirements of law.

Others who use tobacco on school grounds will be informed of this policy and asked to comply. A person failing to comply will be asked to leave school grounds. A person who refuses to comply or to leave school grounds when requested to do so under this policy may be referred for prosecution as a trespasser.

For purposes of this policy, "school grounds" means any property and facilities owned or leased by the school and used at any time for school related activities, including but not limited to school buildings, areas adjacent to school buildings, athletic fields and parking lots.

# EMERGENCY/DISASTER PREPAREDNESS

## STATEMENT OF PURPOSE:

All schools should develop an emergency response plan.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 33 - Fire and Emergency Preparedness Drills
- Vermont School Quality Standards, Section 2120.8.2.3
- Vermont State Board of Education Manual of Rules and Procedures - Rule 4102

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLE:

Be knowledgeable about the school nurse's role in an emergency.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Serve on the school's response committee that develops the emergency plan.
2. Participate in reviews and drills of this plan.
3. Be involved in the evaluation and revision of the emergency plan.
4. Coordinate advance procedures with EMS, physicians and hospital emergency room staff.
5. Serve on community-wide planning groups that assess the school's ability to manage an emergency and determine emergency plans.
6. Identify unique emergency preparedness needs for children with special needs.
7. Survey staff members identifying skills, training and capabilities. (see attached)
8. Be a resource to school and broader community.
9. Plan in advance for personnel needs during an emergency (i.e. daycare, healthcare needs).
10. Provide triage, direct care and counseling to students, families, staff, and victims of the emergency until the commander of emergency services arrives.

## RESOURCES:


- Doyle J & Loyacono, T. (2002). Disaster Preparedness Guidelines for School Nurses. Castle Rock, CO: National Association of School Nurses.
- Maloney, P., Fitzgerald, S., Elam, K., & Doyle, J (2000). Managing School Emergencies III, Scarborough, ME: National Association of School Nurses.
- National Association of School Nurses - www.nasn.org link to position statement, "School Nurse Role in Emergency Preparedness"
- Romig, L (2002) JumpSTART pediatric multiple casualty incidents triage. Available at www.jumpstarttriage.com
- Vermont School Board Association – www.vtvsba.org - link to school crisis response

- Vermont School Crisis Guide, 2004, http://www.state.vt.us/educ/new/html/resources/model_policies/crisis_guide_04.html
- Vermont Department of Health local district offices

**SAMPLE POLICIES, PROCEDURES, AND FORMS:**

Staff Skills Survey and Inventory

# STAFF SKILLS SURVEY & INVENTORY

Name & School _____ (Name) / _____ (School) Room _____

During any disaster situation, it is important to be able to draw from all available resources. The special skills, training and capabilities of the staff will play a vital role in coping with the effects of any disaster incident, and they will be of paramount importance during and after a major or catastrophic disaster. The purpose of this survey/inventory is to pinpoint those staff members with equipment and the special skills that might be needed. Please indicate the areas that apply to you and return this survey to your administrator.

**PLEASE CHECK ANY OF THE FOLLOWING IN WHICH YOU HAVE EXPERTISE & TRAINING. CIRCLE YES OR NO WHERE APPROPRIATE.**

_____ First Aid (current card yes/no) _____ CPR (current yes/no) _____ Triage _____ Firefighting

_____ Construction (electrical, plumbing, carpentry, etc.) _____Running/Jogging

_____ Emergency Planning _____ Emergency Management _____ Search & Rescue

_____ Law Enforcement Bi/Multi-lingual (what language (s)) _____

_____ Mechanical Ability _____ Structural Engineering _____ Bus/Truck Driver (Class 1 or 2 license yes/no)

_____ Shelter Management _____ Survival Training & Techniques _____ Food Preparation

_____ Ham Radio Operator _____ CB Radio _____Journalism

_____ Camping _____ Waste Disposal _____ Recreational Leader

DO YOU KEEP A PERSONAL EMERGENCY KIT? _____ In your car? _____ In your room?

DO YOU HAVE MATERIALS IN YOUR ROOM THAT WOULD BE OF USE DURING AN EMERGENCY? (i.e., athletic bibs, traffic cones, carpet squares) _____ Yes _____ No

DO YOU HAVE EQUIPMENT OR ACCESS TO EQUIPMENT OR MATERIALS AT YOUR SCHOOL SITE THAT COULD BE USED AN IN EMERGENCY? _____ YES _____ NO
PLEASE LIST EQUIPMENT AND MATERIALS.

_____

_____

COMMENTS

_____

_____

WHAT WOULD MAKE YOU FEEL MORE PREPARED SHOULD A DISASTER STRIKE WHILE YOU WERE AT SCHOOL?

_____

_____

# ENVIRONMENTAL HEALTH

## STATEMENT OF PURPOSE:

All schools should establish and maintain an environment free from toxins, pollutants and hazardous materials.

## AUTHORIZATION/LEGAL REFERENCE:

- Vermont Act 125 of 2000 - Indoor Air Quality
- State Board of Education Manual of Rules and Practice, Section 6131

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLE:

Collaborate with administrators, maintenance personnel, health educators and classroom teachers, to:

1. determine if environmental health problems or potential problems exist in the school;
2. prioritize problems with respect to health risks to the general school population;
3. establish a plan of action to mitigate or eliminate, to extent possible, any existing environmental health problems;
4. create a method to manage environmentally-related health questions, concerns, complaints and incidents as they occur. Encourage discussion with school health action committees; and
5. promote environmental health awareness through dissemination of resources.

## RESOURCES:

- Environmental Protection Agency Indoor Environment Division. Indoor Air Quality Tools for Schools: Action Kit - http://www.epa.gov/iaq or 1-800-438-4318
- Vermont Department of Health, Envision manual - http://www.healthyvermonters.info/hp/act125/envision.shtml

# EVALUATION OF HEALTH SERVICES

## STATEMENT OF PURPOSE:

All school nurses should participate in the evaluation of the school's health services and their own professional practice.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A Chapter 3 § 165 – Standards of quality for public schools
- School Quality Standards, Sections 2120.4, 2120.5 and 2120.8
- Vermont State Board of Education Manual of Rules and Practices, Section 5432

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Develop a portfolio for documentation of personal learning and professional growth (i.e. professional workshops and courses, presentations to educational staff, evidence of liaison work with community partners and develop forms used in communication and record keeping).
2. Develop performance indicators and yearly goals with administration. These criteria should be based on professional nursing practices. For example:
    - Participation in professional meetings.
    - Interactions with parents and students.
    - Execution of interventions in safe and appropriate manner.
    - Processes for referral of health needs to medical home.
3. Establish a system of data collection to support performance indicators, yearly goals and completion of required reports (i.e. state screening report, and VDH immunization report).

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Develop process for reporting health service use and analysis of health coverage based on need.
2. Make recommendations to administration about ways to improve school health services.
3. Complete the CDC School Health Index

## RESOURCES:

- Ackerman, P. M. (1995). Job Performance Guidelines for School Nurses. Scarborough, ME: National Association of School Nurses.
- National Association of School Nurse - www.nasn.org
- Proctor, Lordi, & Zaiger, School Nursing Practice: Roles and Standards (1993).
- School Health Index developed by CDC & available at: http://apps.nccd.cdc.gov/shi/HealthYouth/intro.htm

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

- Guidelines for Evaluation of School Health Services
- Summative Evaluation Processes

| School Health Services Evaluation | |
|---|---|
| **I. General School Health Services** | **Documentation/Comments** |
| Does school meet School Quality Standards (i.e. full-time school nurse to student ratio 1/500) | |
| Purpose and scope of the school health program has been defined by written policies (HIV, Crisis Response, Child Abuse and Substance Abuse). | |
| Specific written school health procedures are available (Delegation, Health Care Plans, Sub. Plans). | |
| Responsibilities of different classifications of school health personnel are clearly defined. | |
| Uses consultative services, i.e. physician, DOH and DOE. | |
| Personnel are currently certified in First Aid and CPR. | |
| Cumulative health records are maintained and kept following school policy. | |
| The school health services program undergoes periodic evaluation (i.e. State Screening, Immunization and Yearly Evaluation Reports). | |
| Have protocol for annually updating student health information. | |
| Have 504/IEP Input. | |

| **II. Specific School Health Services** | **Documentation/Comments** |
|---|---|
| There is a written job description for the School Nurse/Associate School Nurse | |
| There is a written job description for other health personnel | |
| A School Nurse Supervisor/Coordinator is available for consultation | |
| The School Nurse ratio is not more than 1 to 500 for the general student population | |
| Screenings are conducted as described in the Standards of Practice: School Health Manual | |
| Disabled or chronically ill students are identified and have an individual health care plan | |
| The School Nurse/Assoc. School Nurse is responsible for participating in the appropriate placement of students with medical needs. | |
| School health office/workspace is accessible to every student | |
| Selected data is collected on student's health screening and sent to DOE at the end of the year in the annual report | |
| Participates on a Coordinated School Health Team | |
| Acts as a health education resource | |
| There is a computer available to the nurse | |

**Guidelines for Evaluation of School Health Services adapted from:**

Developing Quality Programs for Pupil Services. (1999). Middletown, Ct: Connecticut State Department of Education.

Evaluating School Nursing Practice: A Guide for Administrators. (1987). Kent, OH: American School Health Association.

Standards of Nursing Practice. (1998). Scarborough, ME: National Association of School Nurses'.

Task Force of School Nursing. (1983) Standards of School Nursing Practice. Kansas City, MO: American Nurses' Association.

Task Force on an Evaluation Guide for School Nursing Practice. (1987). Evaluating School Nursing Practice: A Guide for Administrators. Kent, OH: American School Health Association.

Virginia School Health Guidelines. (2nd ed.). (1999). Richmond, VA: Commonwealth of Virginia, Department of Education.

# School Nurse Summative Evaluation Process

School Name: _____

| | Meets Performance Responsibilities | See Comments Section |
|---|---|---|
| **School and Community:** | | |
| Acts as a health consultant to staff, students and facility | ( ) | ( ) |
| Available for advice and support to students, staff and family | ( ) | ( ) |
| Participates in faculty meetings (expectation of school nurse only) | ( ) | ( ) |
| Is involved in pre-school, kindergarten, and/or first grade registration | ( ) | ( ) |
| Serves as a resource person for health education (expectation of school nurse only) | ( ) | ( ) |
| Serves as a member of the I.E.P./basic staff planning teams | ( ) | ( ) |
| Case manages 504 students with special health needs (expectation of school nurse only) | ( ) | ( ) |
| Monitors the conditions for a healthful school environment | ( ) | ( ) |
| Networks with other community, health Professionals (i.e. Physicians, VDH, Social Services, Mental Health Services) | ( ) | ( ) |

| | Meets Performance Responsibilities | See Comments Section |
|---|---|---|
| **School Health Services:** | | |
| Screenings: | | |
| Immunization | ( ) | ( ) |
| Vision | ( ) | ( ) |
| Hearing | ( ) | ( ) |
| Maintains accurate records: | | |
| Student health records | ( ) | ( ) |
| Daily log | ( ) | ( ) |
| Accident reports | ( ) | ( ) |
| Staff health records | ( ) | ( ) |
| Local & State health reports | ( ) | ( ) |
| Assess student's health status | ( ) | ( ) |
| Provides first aid for injury or illness when needed | ( ) | ( ) |
| Provides teaching when necessary for illness or injury | ( ) | ( ) |
| Provides necessary teaching of personal hygiene on an individual basis | ( ) | ( ) |
| Makes appropriate referrals to parents | ( ) | ( ) |

COMMENTS:

| | Meets Performance Responsibilities | See Comments Section |
|---|---|---|
| **School Health Services continued:** | | |
| Provides input into adaptation needs of the special-needs students | ( ) | ( ) |
| Interprets health data for members of the staff | ( ) | ( ) |
| Provides necessary in-service training for faculty | ( ) | ( ) |
| Prepares health budget | ( ) | ( ) |
| Health polices have been officially adopted, implemented & updated: | | |
| immunization | ( ) | ( ) |
| medication | ( ) | ( ) |
| communicable diseases | ( ) | ( ) |
| illness | ( ) | ( ) |
| injury | ( ) | ( ) |
| child abuse & neglect | ( ) | ( ) |
| substance abuse | ( ) | ( ) |
| other health related policies | ( ) | ( ) |
| Annually evaluates the health services program | ( ) | ( ) |
| Demonstrates skills in planning, organizing, and implementing the school health service program | ( ) | ( ) |

COMMENTS:

| | Meets Performance Responsibilities | See Comments Section |
|---|---|---|
| **Professional Knowledge and Growth:** | | |
| Credentials: | | |
| Certified as a School Nurse/Associate School Nurse by VT Dept of Education | ( ) | ( ) |
| Current CPR Certified | ( ) | ( ) |
| Other (specify) | ( ) | ( ) |
| Educational Improvement and Professional Participation | | |
| Workgroups | ( ) | ( ) |
| College Courses | ( ) | ( ) |
| In-service Programs | ( ) | ( ) |
| Other (specify) | ( ) | ( ) |

COMMENTS:

_____ _____
Evaluator's Signature Date

_____ _____
Nurse's Signature Date

# FIRST AID

## PURPOSE STATEMENT:

School employees are responsible for the appropriate handling of first aid and emergency situations as they arise during the school day and during school sponsored activities.

## AUTHORIZATION/LEGAL REFERENCE:

- 12 V.S.A. Chapter 23 § 519 - Emergency Care
- Vermont School Quality Standards, Section 2120.8.1.3.3

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Be trained annually in CPR. Maintain professional readiness by attending first aid courses and other conferences/courses/classes.
2. Provide first aid to students as necessary.
3. Document visits to the health room in the individual student's health record and/or visit sheet. (See documentation section)
4. Ensure a written accident report is prepared within 24 hours of any accident. Reports should be completed by the person witnessing the emergency or by an appropriate staff member. A copy of the report should be given to the building administrator. Accident reports should be maintained in a separate file, not in the student's health record.
5. Contact parents/guardians as soon as possible within 24 hours of any incident.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLE:

1. Maintain appropriate first aid supplies in the health office
2. Maintain portable first aid supplies.
3. Educate staff as appropriate in use of Individual Health Plans (IHP) and universal precautions.
4. Maintain current phone number and emergency contact information about each student.
5. Encourage ongoing communication between parent/guardian, attending medical home and the school nurse regarding recuperative periods, details for re-admission to school and follow-up care.
6. Review accident/incident report data and share findings with the school administrator.

## RESOURCES:

- American Red Cross - http://www.redcross.org/
- American School Health Association http://www.ashaweb.org
- Dental First Aid - http://smilevt.org/pdf/topic/Dental_First_Aid.pdf
- National Association of School Nurses http://www.nasn.org
- Vermont State School Nurses Association http://www.vssna.org

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

- Accident Report Form
- Recommended Health Office Supplies
- Recommended Field Trip Supplies
- Recommended Supplies for Emergency Bag

# Accident Report Form

Fill out in duplicate, copies to Principal and School Nurse

School District: _____

School: _____

**TO BE FILLED IN AT THE TIME OF THE ACCIDENT BY THE PERSON CARING FOR THE STUDENT OR INJURED ADULT**:

Date: _____ Time: _____

Student/employee name: _____ Grade: _____
Address: _____
Location of accident: _____
Activity student/employee was engaged in (be specific): _____

---

Staff on Duty: _____
Complete description of accident: _____
_____

---

Assessment of injury (body, degree of injury, functional effect) _____
_____

---

Initial Treatment of injury: _____
By Whom: _____
Disposition: _____
Was the injured transported to a medical facility? _____
Was school nurse present and/or notified? Yes____ No ____ by Whom _____
Were parents notified? Yes ____ No ____ Time _____ by Whom _____
Follow up/outcome of the injury _____
Were there any safety hazards that may have precipitated the accident? _____
Has that been addressed with appropriate personnel? _____ Who _____

---

Signature of person preparing report: _____

Signature of school Nurse: _____

Principal's Signature _____ Date: _____

Notes:

---

# RECOMMENDED SUPPLIES FOR THE HEALTH OFFICE

**Bandages**
Sterile 4x4s
Non-sterile 4x4s
Non-stick dressing (Telfa)
Band aids 1", 2"
Rolled bandages
Hypoallergenic tape
Bulky dressing (Peri pad/ABD)
Splints (firm/bendable cardboard)
Triangular bandages/Sling/Safety Pins

**Medication**
Tylenol
Benadryl (emergency use)
Epi Pen (obtain order from local MD)
Glucose tabs/gel or juice
Bacitracin

**Suggested**
Baby Aspirin
Saltine crackers
Tooth boxes
Extra large BP cuff
Otoscope
Lighted magnifying glass
Scissors – EMT type
Apron for impervious material
Latex free band aids
Elastic wraps (ACE)
SamSplint
Tongue blades
Medication for students:
Tums/Advil/Cough syrup/Other
Toothbrush/paste
Hair ties/comb
Adhesive Remover
Reusable Ice packs

**Paper work**
Emergency Phone numbers
Poison Control numbers
Incident/accident form
Medication form
Student health form
Phone numbers of parents/contacts

**Other**
Wash Basin
Emesis container
Scissors, bandage type
Antiseptic sol'n (Betadine/Phisoderm)
Thermometers
Feminine hygiene supplies
Non latex gloves
Pocket mask
Clorox
Surface disinfectant
Paper cups
Paper bags (hyperventilating)
Plastic bags
BP cuff: adult and child
Stethoscope
Permanent marker (laundry marker)
Safety Pins
Flashlight and batteries
Eye cup
Eye Rinse Sol'n (saline)
Protective eyewear (goggles)
Ice
Hot compress
Baggies (for ice cubes/other)
Salt (salt-gargle/swish)
Cotton balls
Peroxide
Alcohol
Calamine lotion
Vaseline (chapped lips)
Cotton tipped applicators
Plain applicators (lice sticks)
Hand lotion
Orthodontic wax
Dental floss
Lancets
Sharps disposal container
Tweezers
Nail clippers
Reference books: medication, emergency, pediatric

## RECOMMENDED SUPPLIES FOR FIELD TRIP KITS

First Aid Field Trip bags may be recycled lunch boxes, fanny packs or just a resealable plastic bag. Different bags work well for different situations, locations and teacher preference; some prefer to carry it separate, other like to stuff it in a backpack.

Large and small band aids
Sterile 4x4's
Non sterile 4x4's
Hypoallergenic tape
Gloves
Safety pins
Menses supplies
Tissues
Plastic bags
Instant ice
Hand Sanitizer Gel

Emergency Phone numbers
Poison Control number
Incident/accident form
Note paper/pen
School phone number

Phone numbers and location of the local (field trip location) rescue squad and hospital should be updated before each field trip.

Each teacher should take a copy of student emergency cards/significant alerts.

## RECOMMENDED SUPPLIES FOR PLAYGROUND KITS

Playground bags may be fanny packs or recycled lunch boxes.

Band aids
Gauze pads
Tissues
Gloves
Small note pad/pencil
Instant ice packs
Waterless hand cleaner

## RECOMMENDED SUPPLIES FOR EMERGENCY BAG

Sterile 4x4's

Non-sterile 4x4's

Non-stick dressing (Telfa)

Band aids 1", 2"

Rolled Bandages

Hypoallergenic tape

Bulky dressing (Peri pad/ABD)

Splints (firm/bendable cardboard)

Triangular bandages/Sling/Safety pins)

Epi Pen (obtain order from local MD)

Glucose tabs/gel or juice

Bacitracin

Hand Sanitizer Gel

Scissors, bandage type

Vinyl gloves

Pocket mask

Paper bags (hyperventilating)

BP cuff: adult and child

Stethoscope

Safety pins

Flashlight or penlight

Eye Rinse sol'n (saline)

Protective eyewear (goggles)

Instant Ice

Apron of impervious material

SamSplint

"Space/solar" blanket

Spirits of ammonia

Plastic bags

Emergency Phone numbers

Poison Control number

Incident/accident form

Note paper/pen

During a FIRE DRILL it is recommended the Emergency Bag as well as a notebook containing the Individual Health Plans is carried by the nurse.

# HEALTH APPRAISAL OF STUDENTS

## STATEMENT OF PURPOSE:

All schools should establish a process for appraising the physical and mental health of the students and a process for providing health counseling to students and their parents/guardians.

## AUTHORIZATION/LEGAL REFERENCE:

Vermont School Quality Standards, Section 2120.8.1.3.3

## DEFINITION:

**Health appraisal** - the process of determining an individual's health status including physical, mental, and social health through such means as health history, parent, teacher and school nurse observations and screening procedures.

**Health counseling** – the process of providing guidance to students and families about eliminating or minimizing health problems that interfere with effective learning and help students to accept and adjust positively to their physical, mental and social conditions.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Collect information about the student's health status according to the screening requirements and school policies. (See screening section)
2. Evaluate the information obtained.
3. Notify parents about areas of concern.
4. Develop a health care plan with the family and the medical home if indicated and evaluate the care plan on a regular basis.
5. Reassess the student's health status as needed.
6. Encourage students /parents/guardians to establish and use a medical home on a regular basis for health supervision and ongoing care. Facilitate referral to medical home for students who do not have one. (See Medical/Dental Home section)

## RESOURCES

Department of Health, Health Screening for Children & Adolescents Provider's Toolkit

## SAMPLE POLICIES, PROCEDURES AND FORMS

- Primary School Health Entry Questionnaire
- Student Emergency Information Card

**Primary School Health Entry Questionnaire**
**SCHOOL HEALTH ENTRY FORM - CONFIDENTIAL**

Student's Name:_____Date: _____

Student's Doctor: _____Phone: _____

Student's Dentist: _____ Phone: _____

Please attach a current copy of student's immunization record or moral/medical exemption form (form is available at school on request). Immunization records and/or moral/medical exemption forms are required by Vermont Law.

Is the student currently being treated for any illness or condition the school should know about? ____ No ____ yes Doctor's name if different from above_____

Describe illness: _____

Is the student taking any medications? ___ No ___ Yes Medication _____

**Medical History**

1. Please describe anything unusual that occurred during pregnancy or at birth of this child. (i.e. bleeding, illness or drugs during pregnancy; low birth weight, premature birth, cord around neck, baby blue or yellow, R.H. negative, transfused, extended hospital stay)_____

2. Serious past illnesses: _____

3. Hospitalizations, operations (give age): _____

4. Serious accidents/injuries - (fractures, trauma to the head, poison ingestion)
_____no ____yes, if so please describe:_____

5. Allergies, Asthma triggers: _____
Medications: _____

6. Childhood illnesses (i.e. chicken pox, high fever, seizures, measles, scarlet fever, strep throat, pneumonia, frequent headaches or bloody noses) – give approximate age.
_____

7. Ears Infections? ___no ___yes infrequent (2-3/yr) ___ frequent (more than 3/yr) ___

Has hearing ever been tested? ___no ___ yes
Any hearing difficulties? ___no ___yes, describe_____

8. Eyes – Has vision been tested? ___no ___yes
Any vision or eye problems? ___no ___yes, describe glasses needed _____

9. Long-term or chronic illnesses or problems (i.e. diabetes, bed wetting, cystic fibrosis, head banging)
_____

_____

Describe care or medication needed : _____

_____

10. Physical or motor difficulties: _____

_____

11. Family History of:

Diabetes: _____

High blood pressure: _____

Heart disease: _____

Seizures: _____

Cancer: _____

12. Anything else we should know about your child? _____

_____

_____

Parent / Guardian Signature _____ Date _____

**STUDENT EMERGENCY INFORMATION AND HEALTH UPDATE FORM**

(A new card should be completed each year. Please notify the school if any information changes.)

PLEASE PRINT

Student's Name_____ Birth Date _____

Address_____ Telephone_____

Father_____ Telephone_____
Name Place of Employment Work Hours

Mother_____ Telephone_____
Name Place of Employment Work Hours

Regular day care/sitter name_____ Telephone_____

Please list two (2) nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached.

1._____ Telephone_____
Name Address

2._____ Telephone_____
Name Address

Does your child have any health problem, illness, or disability that the school should be aware of?_____

Please explain how the condition should be managed at school._____

_____

Current Medications:_____

_____
(Name, dose, frequency)

Allergies:_____

## Student Emergency Information Card

In case of accident or illness, I request the school to contact me. If not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including notifying my child's doctor and transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Signature of parent/guardian: _____ Date: _____

Date of recent immunizations: _____
(DPT, Td, MMR, HepB)

Does your child have health insurance? Yes _____ No _____

| | Telephone | Last Seen | None |
|---|---|---|---|
| **Child's Primary Care Provider** | | | |
| **Child's Dentist** | | | |

| Siblings: | Last Name | First Name | DOB | Grade |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## Permission for Over the Counter Medications

My child has permission to receive the following medications at schools:

_____ Acetaminophen (Tylenol)
_____ Bacitracin antibiotic ointment
_____ Calamine Lotion (for insect bites)
_____ Chloroseptic lozenges (for sore throats)
_____ Benadryl (for allergic reactions)
_____ Robitussin DM cough syrup (for excessive cough)
_____ TUMS antacid
_____ Cough drops
_____ Visine A.C.
_____ Hydrocortisone cream for contact dermatitis
_____ Proxigel for canker sores

_____ _____
Parent/Guardian Signature Date

# HEALTH EDUCATION

## STATEMENT OF PURPOSE:

All schools are required to provide comprehensive health education to K-12 students.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 1 § 131 - Definitions
- 16 V.S.A. Chapter 1 § 134 - Religious exemption
- 16 V.S.A. Chapter 1 § 135 - Program development
- 16 V.S.A. Chapter 23 § 909 – Tobacco, alcohol and drug prevention education curriculum
- 16 V.S.A. Chapter 25 § 1165 - Act 51

## SUGGESTED SCHOOL NURSE ROLES:

The school nurse may, in collaboration with administrators, guidance personnel, nutritional services personnel, health educators and classroom teachers:

1. Assist teachers with reference material, educational resources and curriculum planning.
2. Provide teachers and students with nursing expertise when health related problems/questions arise.
3. Assist agencies to coordinate community-based health education programs.
4. Provide students with periodic in-class supplemental instructions and small group/one-on-one instruction.
5. Provide faculty/school personnel with in-service education programs (e.g. drug and alcohol, nutrition, personal safety).
6. Provide family/groups/community with education programs (e.g. drug and alcohol, adolescent development, personal safety programs).

## RESOURCES:

- American Cancer Society of Vermont - http://www.cancer.org/docroot/home/index.asp
- American Heart Association - http://www.americanheart.org/
- American Lung Association of Vermont - http://lungaction.org/ala_vt/home.html
- American Red Cross - http://www.redcross.org/
- Safe and Healthy Schools Coordinated School Health Workgroup - http://www.state.vt.us/educ/new/html/pgm_coordhealth.html
- Vermont Department of Education. Vermont Health Education Guidelines for Curriculum and Assessment. 2002
- Vermont Department of Health - http://www.healthyvermonters.info/
- Vermont Department of Health - http://www.state.vt.us/adap/
- Vermont Health Education Resource Centers http://www.state.vt.us/educ/new/html/pgm_coordhealth/herc/herc.html

# IMMUNIZATIONS

## STATEMENT OF PURPOSE:

All schools must collect proof of immunization or exemption from students. This proof is required for school attendance.

## AUTHORIZATION/LEGAL REFERENCES:

- 18 V.S.A. Chapter 21 § 1121 - Immunizations required prior to attending school
- Vermont Department of Education Memorandum on Retention of Immunization Records, October 15, 2002

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Follow the Vermont Department of Health manual for enforcement of the school immunization law.
2. Review all immunization records of students prior to entering the school system.
3. Maintain immunization record of all students within the school community.
4. Complete the annual immunization status report for the Vermont Department of Health.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Develop protocol for tracking of students without adequate immunization.
2. Establish list of students with medical, religious or moral exemptions to immunizations.
3. Collaborate with administration about procedures for exclusion of students not compliant with immunization law.
4. Notify parent(s)/guardian of the need for additional immunizations or adequate documentation.
5. Contact local medical home to establish protocol for sharing immunization information.
6. Hold immunization clinics at school following these requirements: A school designated physician must authorize and oversee the administration of vaccine and emergency response procedures.
7. Review immunization requirements for immigrants/refuges.

## RESOURCES:

- Procedures for Enforcement of the School Immunization Law", Vermont Department of Health manual
- Vermont Department of Health Immunization Program - 1 – 800-464-4343, Ext. 7638

# LIABILITY

## STATEMENT OF PURPOSE:

School nurses must assume personal and professional liability for their actions.

## AUTHORIZATION/LEGAL REFERENCE:

- 12 V.S.A Chapter 23 § 519 - Emergency medical care
- 16 V.S.A Chapter 53 §1756 - Protection of school directors, teachers, employees, and board members in damage suits.
- 26 V.S.A. Chapter 28 – Nurse Practice Act

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Know the Vermont Nurse Practice Act.
2. Know the Standards of School Nursing Practice (NASN).
3. Obtain professional liability insurance.
4. Know risk prevention and management strategies.

## RESOURCES:

- American Nurses' Association (ANA) – www.ana.org
- National Association of School Nurses - www.nasn.org
- National Education Association - www.nea.org
- Nurses Service Organization - www.nso.com
- Pohlaman, J. & Schwab, N. (2000)( Managing Risks in Professional and Clinical Performance Dilemmas: Part 1. *Journal of School Nursing, 16(2), 46-48.*
- Schwab, N., & Gelfman, M. *Legal Issues in School Health Services*, Sunrise Press, 2001.
- Vermont NEA, Montpelier, Vermont - http://www.vtnea.org/
- Vermont State Board of Nursing – http://professional.org.opr1/nurses/forms/nursingrules

## SAMPLE POLICES, PROCEDURES AND FORMS

Risk Prevention and Management

**Risk Prevention and Management- adapted from Nadine Schwab, March 1996.**

## Recurring Causes of Nursing Liability

1. Failure to keep abreast of nursing knowledge
2. Failure to take an adequate patient history
3. Failure to function within established policies
4. Failure to function within the scope of nursing education and practice
5. Failure to administer medications and treatments properly.
6. Failure to adequately supervise or monitor patients
7. Failure to observe and report changes in a patient's condition
8. Failure to document adequately and promptly: Alteration of records
9. Failure to report incompetent care by others
10. Improper physician orders - duty to defer execution
11. Failure to use aseptic technique
12. Use of defective equipment
13. Abandonment of patient
14. Failure to resuscitate promptly and properly

## Strategies to Avoid Liability

1. Know the laws/standards that apply to your practice
2. Establish, regularly update and function according to agency, policies, procedures, job descriptions, nursing protocols and standing orders
3. Keep up-to-date in your clinical practice
4. Document in writing notification of unsafe conditions
5. Develop statistical data to document concerns
6. Keep complete, accurate records of care
7. Apply the principles of good recording to all documentation
8. Obtain adequate consent to provide care, perform procedures
9. Document student/family education/notification
10. Protect the student/family's right to confidentiality
11. Avoid verbal physician orders
12. Do not over-delegate
13. Initiate quality assurance/risk management programs
14. Use the expertise of, and network with, advanced practice registered nurses and physicians in the community who are clinically competent in serving the primary health needs of your student population.
15. Educate your policy makers (standards of care; risks)
16. Educate your community - your consumers
17. Budget monies for medical-legal consultation to help resolve conflicts with educational policies, procedures or legal opinion.
18. The nurse-student relationship must supersede all others

# LICENSING & ENDORSEMENT

## STATEMENT OF PURPOSE:

The Vermont Department of Education grants endorsements of school nurse or associate school nurse status to qualified Registered Nurses.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 51 – Examination and licensing of teachers
- 26 V.S.A. Chapter 28 § 1571 and § 1584 - Nurse Practice Act
- School Nurse and Associate School Nurse Licensing Regulation 5440-65 and 65A

## REQUIRED SCHOOL NURSE ROLES:

1. Maintain current Vermont Registered Nurse license.
2. Maintain current Vermont Department of Education endorsement.
3. Develop and maintain an Individual Professional Development Plan (IPDP) according to the local professional standards board.

## RESOURCES:

- Vermont Department of Education, Licensing - http://www.state.vt.us/educ/new/html/licensing/endorse.html
- Vermont State Board of Nursing - http://vtprofessionals.org/opr1/nurses/

# MEDICAL/DENTAL HOME

## STATEMENT OF PURPOSE:

All school-age children and youth should have access to a medical and dental home for preventive, therapeutic and restorative medical/dental care.

## AUTHORIZATION/LEGAL REFERENCE:

Vermont School Quality Standards, Section 2120.8.1.3.3

## DEFINITION

**Medical/Dental Home –** Provision of family-centered care through developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life. Sharing clear and unbiased information with the family about the child's medical/dental care and management and about the specialty and community services and organizations they can access. Provision of primary care, including but not restricted to acute and chronic care and preventive services, including breastfeeding promotion and management, immunizations, growth and developmental assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, nutrition, safety, parenting, and psychosocial issues.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Collect information on the medical/dental update from parents on a yearly basis about:
   a. Name of student's medical/dental home
   b. Date of student's last physical/dental exam
   c. Whether the family has health care coverage
2. Inform all families of the Vermont Medicaid/Dr. Dynasaur program and its benefits.
3. Assist uninsured families in determining their eligibility for participation in Vermont's Medicaid program.
4. Encourage parents to schedule a physical examination and dental examination for their child if it has been more than one year or health concerns are identified.
5. Document findings, referrals and follow-up action in the daily log and student's health record.
6. File any physical dental exam information received in the health record.
7. Promote awareness of and understand the benefits of preventive and remedial medical and dental care.
8. Work with the Vermont Department of Health school liaison and school administration to establish Early Periodic Screening and Diagnostic Testing (EPSDT) agreements and the Tooth Tutor program.
9. Submit data about aggregate student medical/dental data on the DOE annual report.

## RESOURCES:

- Children's Dental Care Guide in Medicaid – http://www.cms.hhs.gov/medicaid/epsdt/default.asp
- Dr. Dynasaur - http://www.smilevt.org/par_dr_d.html
- National Center of Medical Home Initiatives - http://www.medicalhomeinfo.org/
- Vermont Dental Society - http://www.vsae.net/members/vsds.html
- Vermont Department of Health – Local District Offices
- Vermont Department of Health, Dr. Dynasaur program - http://www.dpath.state.vt.us/Programs_Pages/Healthcare/drdynasaur.htm
- Vermont Department of Health, Health Screening for Children & Adolescents Provider's Toolkit
- Vermont Department of Health, The Tooth Tutor Program - http://www.healthyvermonters.info/hi/dentalhealth/dentalservices.shtml#Anchor-Th-18476

## SAMPLE POLICIES, PROCEDURES, AND FORMS

- The Tooth Tutor Program

## The Tooth Tutor Program

Vermont's Tooth Tutor Dental Access Program was developed in response to the concerns of school nurses, teachers, dental hygienists and other health care professionals who have seen that dental disease continues to affect children and has an impact on the development of speech, expressiveness, nutrition and self esteem. The Tooth Tutor Dental Access Program goal is to establish a dental home for each child. A dental home is a place where a person goes to receive preventive, comprehensive and continuous care, as well as a place to turn with dental questions or in cases of emergency.

It provides a system to identify the children in a school who do not have access to regular dental care, and to help families gain access to dental services in their community. The Tooth Tutor program also contains a curriculum so that all members of the school can benefit from the dental health education provided by the Tooth Tutor Hygienist.

- There are currently 120 schools throughout the state participating in the Tooth Tutor Program.
- Most of the hygienists are funded through EPSDT funds, and some are funded through grants.

The first step towards getting a Tooth Tutor Program in a school is to hire a Dental Hygienist.

- Dental Health Services maintains a list of hygienists who have previously expressed an interest in becoming a Tooth Tutor if a position should open up in their area.
- The hygienist will go through the medical history records to determine which children are without a dental home, as well as those children who have not had a dental visit in the last year.
- These children become part of the school's "Target Group."
- The goal of the hygienist at this point is to connect the target group children to local dental homes.
- In 2002, 89% of children in Tooth Tutor schools had a dental home by the end of the school year.

Recently Dental Health Services and Champlain Valley Head Start have teamed up to pilot a Tooth Tutor Program in Addison, Chittenden and Franklin counties.

If you would like more information about Vermont's Tooth Tutor Dental Access Program, please contact Dental Health Services at **1-802-863-7341**.

# MEDICATIONS

## STATEMENT OF PURPOSE:

Schools must assure that medications administered to students are done so in a way that assures safety and compliance with state law and school policies and procedures.

## AUTHORIZATION/LEGAL REFERENCE:

- 26 V.S.A. Chapter 28 - Vermont Nurse Practice Act
- Joint Statement of the Vermont Boards of Medical Practice and Nursing regarding the Administration of Non-Prescription Medications by Registered Nurses, June 5, 1991
- Joint Statement of the Vermont State Boards of Pharmacy and Nursing and the Department of Education regarding the Administration of Medication on School Field Trips, December 6, 2000
- State Board of Education Rules and Regulations, Section 4220- 4222.5 - Prescription Drugs
- Vermont Department of Education and State Board of Nursing – Memorandum Delegation of Authority to Administer Medications, April 14, 2000
- Vermont State Board of Nursing Advisory Opinion - The Role of the School Nurse in administering homeopathic/Herbal and/or Food Additives, November 9, 1998
- Vermont State Board of Nursing Advisory Opinion on Holistic Health, November 9, 1998

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

**Only the school nurse/associate school nurse, the student's parent/guardian, or the school nurse's/associate school nurse's trained designees may administer medication in the school setting.**

1. Assure the safe administration of medication in the school setting and on school field trips.
    a. For prescription medication: secure written orders from the physician detailing the name, dosage, route, frequency and the diagnosis and reason for giving; written permission from the parent/guardian and medication in a container appropriately labeled by the physician or pharmacy.
    b. For non-prescription medication: secure written permission from the parent/guardian and medication in the appropriately labeled original container.
2. Develop protocols for the proper delivery of medications (see attached policy on delegating medications).
3. Develop individual care plans with needed protocols for students receiving the variety of medications requiring specific instructions or activities related to the medication.
4. Provide training, support and supervision to those delegated to administer medications.
5. Participate in the job performance evaluation of those administering medications in school.
6. Document medication administration and medication errors and place in the student's permanent health record.
7. Assist in the development of school polices concerning medications.
8. Review new prescription medications before medications can be given by designee

9. Provide all necessary school personnel with information and possible adverse effects of medications being administered to a student in their care.
10. Maintain communication with the parent/guardian and medical home concerning the medication and the student's response to the medication.
11. Instruct the parent to transport medications to school.
12. Instruct and monitor students who, with a doctor's order, are self-administering their medication in the school setting.
13. Assure that medication is not expired and is stored appropriately in a locked container unless the student is self-administering their medication (refrigerated, locked cabinet, expiration date).

**RESOURCES:**

- American Diabetic Association – http://www.diabetes.org
- Asthma and Allergy Foundation of America – http://www.aafa.org/
- Epilepsy Association of Vermont – P.O. Box 6292, Rutland, VT 05702, 802-775-1686
- Epilepsy Foundation of America – ww.efa.org
- National Association of School Nurses – www.nasn.org
- Santilli, N. (2001). Students with Seizures: A Manual for School Nurses (2nd edition). Landover, MD: Epilepsy Foundation of America.
- The Food Allergy and Anaphylaxis Network - www.foodallergy.org
- Vermont Department of Health Diabetes Control Program Manual. (1999). Recommendations for Management of Diabetes for Children in School Burlington, VT: Vermont Department of Health.
- Vermont Department of Health. (2003). Managing Asthma at School Burlington, VT:
- Vermont State Nurse Association - http://www.vsna-inc.org/

**SAMPLE POLICES, PROCEDURES AND FORMS:**

- Sample Policy on Administration of Medication in the Schools Setting
- Prescription Medication Order and Permission Form
- Parent Permission for Administration of Non-prescription Medications
- Medication Protocol
- Conformation of Training to give Medications in the School Setting
- Medication Error Report
- Medication Protocol for Field Trip
- Field Trip Emergency Information and Medical Form
- Asthma Action Plan
- Medication Logs

## Sample Policy on Administration of Medication in the Schools Setting

### Prescription Medication:

The _____ school recognizes that at the present time many children are able to attend regular school because of the effective use of prescribed medication in the treatment of chronic disabilities or illnesses. It is more desirable for medication to be administered in the home; however, the parent/guardian of any student (unless the student is 18) who is required to take prescribed medication during the regular school day must comply with the following regulations:

1. Written orders from a physician detailing the name of the student, the drug dosage, reason for giving, and time medication is to be given must be received by the school nurse/associate school nurse, or the designee of the school nurse/associate school nurse and/or the building administrator before the medication can be given. A renewal of a long-term medication order is required each school year.
2. Written permission from the parent/guardian of the student requesting that the school district comply with the physician's order must accompany the physician's order.
3. Medication must be brought to school in a container appropriately labeled by the pharmacy or medical home. A second pharmacy properly-labeled bottle should also be obtained for field trips.
4. Medication shall be kept in the school health office. Students with chronic illnesses (e.g. seizure disorders, cystic fibrosis, diabetes, etc.) who are responsible for administering their own medications should be allowed to continue the practice. Those students wishing to carry their own medication at school must have a medical provider's order to do so and a safe place to store the medicine. The school nurse/associate school nurse must instruct the student of safe use of the medicine at school before the student can carry the medicine on their own. The student is expected to notify the nurse or other designated school personnel when the medicine is used. Any student found not to be responsible for the safe-keeping and use of the medicine will have to give it to the nurse, and the nurse/designated school personnel will administer the medicine.
5. Medication must be stored in a locked cabinet.
6. The above procedures must be followed for all prescription medication.
7. Unused medication shall be destroyed or returned to parent/guardian for disposition.
8. All medication must be brought to school by the parent or guardian. For safety reasons, students should not bring medicine to school on the bus.
9. When medication is administered at school, only the school nurse/associate school nurse or the school nurse’s trained designees may administer the medication in compliance with the school’s policy.
10. A student’s first dose of any medication they have not taken before should occur at home. Successive doses given at school for the first time need to be reviewed by the school nurse before administration of the medication.

# Policy on Administration of Medication in the School Setting

## Non-Prescription Medication:

1. The school nurse/associate school nurse must be notified if a non-prescription medication is to be used during school hours or activities.
2. The policy and procedure for non-prescription medication shall be developed by each school district if that district chooses to treat non-prescription drugs differently than prescription drugs.
3. Non-prescription medications will be administered only with a permission form that has been signed by the parent or with documented verbal permission that is followed by written permission the next day. The medicine must be in the originally labeled bottle or box and must be left in the health office, unless the student has written permission from the parent and medical home and approval of the school nurse/associate school nurse to carry and use the medication in the school setting.

**Prescription Medication Order and Permission Form**

***(To be returned to the School Nurse/Associate School Nurse)***

Date _____

I hereby give my permission to _____ to release
Primary Care Provider

information to _____ concerning medication(s)
School Name

prescribed for _____.
Name of Student

**Signature of Parent of Guardian_____**

**********

Medication _____

Directions _____

Beginning Date _____ Last Dose_____

Reason for Giving _____

**Signature of Primary Care Provider _____**

**********

I hereby give my permission for the above named student to take the medication as prescribed above at school.

**Signature of Parent of Guardian_____**

**********

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician.

All medicine brought into the school must be kept in the health room during school hours.

**Date Received _____ Signature of School Nurse _____**

**Parental Permission for**
**Administration of Non-prescription Medication**
***(To be returned to the School Nurse/Associate School Nurse)***

I hereby give my permission for:

Name of Student_____

in grade _____ at _____ School

to take:

Medication_____ Dosage_____

Directions_____

Reason for Giving_____

Date_____

Signature of Parent/Guardian_____

No non-prescription medication will be given at school until the school receives this completed form with the medication provided in its original container.

All medicine brought into the school must be kept in the health room during school hours.

Date Received: _____

Signature of School Nurse: _____

## Protocol for those who have been delegated to administer medications

1. Make sure you have:
   **a. For prescription medication:**
   Permission from both the parent and the medical home
   Medication in a current pharmacy-labeled bottle
   b. **For non-prescription medication**:
   Permission from the parent
   Medication is in original store-labeled bottle

2. A student's first dose of any medication they have not taken before should occur at home. Successive doses given at school for the first time need to be reviewed by the school nurse before administration of the medication.

3. If you have questions and the school nurse cannot be reached contact the medical home.

4. Prepare a medication log sheet for the medication log book and staple written permissions slips from parent and doctor to the medication sheet for the student.

5. Check confidential medical sheet for highlighted allergies to medicines.

6. Observe good hand washing practices.

7. Check to see if you have observed the five rights for giving medication. Do you have the right:

   1. medications
   2. child
   3. time
   4. route (mouth, ears, eyes, skin); and
   5. amount

8. Identify the student and give medication.

9. Record that you have given the medication on the medication sheet in the medication book. Include the following information:

| | <u>Already on Medication Sheet Normally</u> |
|---|---|
| Date | Name of student |
| Time | Medication |
| Your initials | Dose |
| Peak flow readings for asthmatics | |

10. Medication box should be locked when not in use or you leave the area.

11. If for any reason a child does not receive their medication or does not receive it at the appropriate time the parent must be called and a Medication Error Report filled out.

**Medications cannot be given without the proper permissions. Notify the parent if you cannot for some reason get permission from the doctor and therefore cannot give the medicine. If medication comes in without parent and physician permission slip you must complete the following:**

**For prescription medicine**

1. Call the physician's office to obtain information and verify order with a FAX to follow up. Gather information about; name of medication, dose, time/frequency to administer.
2. Call the parent to obtain verbal permission to administer one dose with written permission to follow.
3. In the medication log book on the back of the medication sheet for this particular medication or use a separate sheet of paper. Date and initial any of the above information collected. Staple this information to the medication sheet if necessary. When written permission slips come in, staple them to the back of the medication sheet as well.

**For non-prescription medicine**

Only parental permission is needed. Call the parent and get permission. Record your conversation with the parent on the back of the medication sheet. Record the following; name of the student, the name of the parent you called, the name of the medication, the dose, the time (frequency of repeat i.e. every four hrs) - don't forget this piece of information.

Chart this information on the back of the student's medication sheet or another sheet of paper and staple the information to the medication sheet. Initial and date the permission information gathered. With permission in place the medication should then be administered and recorded with the date and time given and your initials on the front of the medication sheet. No further medication can be given if written permission from the parent is not obtained on the following day.

**Medicine that cannot be identified cannot be administered at school.**

If medication comes to the health office unlabeled (i.e. in a baggy or rolled-up Kleenex), call the parent and explain that medication which is not identified by its properly labeled packaging cannot be given at school.

## Confirmation of Training to Give Medications in the School Setting

**TO BE SIGNED BY MEDICATION DELEGATEE:**

I have been instructed on the proper administration of medications in the school setting by the school nurse. I have read and understand the medication protocols attached to this form. Also I have practiced administering the following medications with supervision by the school nurse/associate school nurse.

Name_____ Date _____
*Medication delegatee*

Medications: 1.
2.

**TO BE SIGNED BY SCHOOL NURSE DELEGATOR:**

I have observed _____
administering the following medication(s) and certify it was done in accordance with the attached medication protocol.

Name_____ Date _____
School Nurse/Associate School Nurse

**(Optional Use: Specific medication may be identified, depending on delegatory situation.)**

# Medication Incident Report

A medication incident is defined as: "failure to administer the prescribed medication within the appropriate timeframe, in the correct dosage, in accordance with accepted practice, to the correct student."

Date of report: _____ School: _____ Prepared by: _____

Student's Name: _____ D.O.B.: _____ Sex: ____ Grade:_____

Home address:_____ Telephone: _____
*street*

_____
*city/town & zip code*

Date incident occurred: _____ Time: _____

Person administering medication: _____

Licensed prescriber: _____
*name/address*

Reason medication was prescribed: _____

Date of order: _____ Instructions for administration: _____

Medication: _____ Dose: _____ Route: _____ Scheduled time: ____

Describe the incident and how it occurred (use reverse side if necessary)

Action taken:

Licensed prescriber notified: Yes ___ No ___ Date _____ Time _____

Parent/Guardian notified: Yes ___ No ___ Date _____ Time _____

Other persons notified: _____

Outcome:

Name: _____ _____ _____
*(Type or print)* *Title* *Date*

_____
*Signature*

Updated 05/28/2008

## Medication Protocol for Field Trips

1. The school health office should be notified of any day time field trip at least a week in advance; overnight field trip notification should be ONE month in advance.

2. Medications, usually taken at home, but required for overnight field trips shall meet the same requirements for safe medication administration within the school setting.

3. The trained school personnel, (delegatee), responsible for the administration of medication shall pick up medications on the morning of the scheduled trip.

4. The medication will be dispensed in a labeled container with the date and time that it is to be given.

5. The trained school personnel administering the medication shall receive training by the school nurse/associate school nurse. The training shall cover the safe administration and delegation of medication. The school nurse/associate school nurse trainer and the delegatee shall sign the dated delegation-training authorization. The delegatee shall be given a copy of the medical order, and a medication fact sheet.

6. All medications, including over-the-counter medications, shall be given to the adult designated by the school nurse/associate school nurse. Exceptions to this policy are those medications deemed "rescue drugs" such as Insulin, Epi-pens and rescue inhalers. Written permission shall be on file for any student to carry self-administering medications.

7. The delegatee shall verify the medication delegation by noting the date, time and their initials following administration of the specific medication. If for any reason a student does not receive the medication within a reasonable time, the delegatee shall notify the parent and school nurse/associate nurse and complete a medication incident report.

8. This procedure shall be followed in both day and overnight field trips.

**Field Trip Emergency Information and Medical Form**

*Fill this form out at the beginning of the year and with every field trip outside the boundaries of the Supervisory Union*

Name of student _____

Address _____ Home phone # _____

Name of parents - Father _____ Phone # _____

Mother _____ Phone # _____

Emergency Information different than parents:

Name _____ Phone #_____

Name _____ Phone # _____

---

List health problems that may affect your child during this field trip
_____
_____
_____

List any known allergies including food, environmental and medication.
_____
_____

List any medications needed during this field trip:
Any prescription medication not taken in school must be delivered in the original container with written permission from the prescribing medical provider and the parent. Over the counter medication must be in the original container with written parental permission only. The school nurse/associate school nurse will designate an adult on the trip to carry and dispense medication needed during the field trip. The school nurse/associate school nurse can provide the medication normally taken at school to that adult.
_____
_____
_____

**********

My child may receive any emergency medical care deemed necessary while on this field trip. Every effort will be made to notify the parent if emergency treatment is necessary.

Date _____ Signature of parent _____

***** The school nurse/associate school nurse will not be going on this field trip*****
****Contact the school immediately with any changes in information.****

---

07554

# Vermont Asthma Action Plan

Date _____ ❑ Initial ❑ Update

| First Name: Last Name: | DOB: |
|---|---|
| School Name: | |
| Provider Name: | Provider Phone # |
| Parent/Guardian Name: | Parent/Guardian Phone #: |
| Emergency Contact: | Emergency Phone # |

**Asthma Type:**
- ❑ Exercise Induced
- ❑ Mild Intermittent
- ❑ Mild Persistent
- ❑ Moderate Persistent
- ❑ Severe Persistent

**Allergies/Triggers:**
- ❑ Cigarette Smoke
- ❑ Colds
- ❑ Molds
- ❑ Grass
- ❑ Exercise
- ❑ Smoke
- ❑ Dust mites
- ❑ Weeds
- ❑ Animals
- ❑ Cold air
- ❑ Trees
- ❑ Stress
- ❑ Other _____

**Personal Best Peak Flow (PF) _____**

**Flu Vaccine _____**

## GREEN = GO

You have **all** of these: PF above _____

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

**DAILY MEDICINE:**

| Medicine | How Much | How Often/When |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**10-15 MINUTES BEFORE SPORTS OR PLAY, USE:** _____

## YELLOW = CAUTION

You have **any** of these PF from _____ to _____

- First signs of a cold
- Cough
- Mild wheeze
- Tight Chest
- Coughing at night

| Medicine | How Much | How Often/When |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**IF NOT BETTER, CALL YOUR HEALTH CARE PROVIDER**

## RED = STOP

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- May/may not wheeze or cough
- Ribs show
- Can't talk well

PF below _____

**TAKE THESE MEDICATIONS AND CALL YOUR HEALTH CARE PROVIDER IF YOU ARE NOT BETTER**

| Medicine | How Much | How Often/When |
|---|---|---|
| | | |
| | | |
| | | |

**STOP! MEDICAL ALERT. This could be a life-threatening emergency. Get Help. Your symptoms are serious. Call your doctor. You may need to go to the nearest emergency room or call 911.**

I, _____ (parent/guardian name—please print) give permission to _____ (school/daycare/homecare name—please print) to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider and administration of medication as needed _____ (signature) Date _____

**The school nurse may administer medications per this action plan:**

_____ (provider signature) **Date** _____

1st Page for Provider 2nd Page for School/Daycare/Homecare 3rd Page for Patient/Parent/Guardian

**For more copies of this form contact the Vermont Department of Health, PO Box 70, Burlington, VT 05402, 1-800-439-8550.**

**Other Important Instructions:**

1. *NO SMOKING*
2. *No smoking in your home or car.*
3. Remove known triggers from your child's environment.

## Environmental Control Measures:

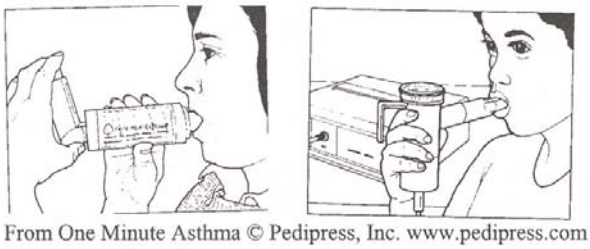
- ❑ No smoking indoors, in car, or anywhere around the child; for help quitting, contact your health care provider or call Vermont's Smoking Quit Line
- ❑ If dust mite allergic, put mattress, pillows, and box spring in zipped covers
- ❑ Remove bedroom rugs/carpets, stuffed animals
- ❑ Keep humidity under 50%
- ❑ Vacuum and surface dust weekly
- ❑ Keep animals out of bedroom or house
- ❑ In pollen season, keep windows closed
- ❑ Wash sheets in hot water weekly
- ❑ Other _____

## For Additional Help and Support, Please Contact:

- ☆ The American College of Allergy, Asthma, and Immunology 800/822-2762, www.acaai.org
- ☆ Asthma and Allergy Network/Mothers of Asthmatics, 800/878-4403, www.aanma.org
- ☆ National Jewish Center's Lung Line, 800/222-5864
- ☆ American Lung Association, 800/LUNGUSA, (1-800 586-4872); www.lungusa.org
- ☆ Vermont's Smoking Quit Line, 877/YES QUIT (1-877 937-7848)

## Medication Tips

- ☆ Have a routine for taking your medications
- ☆ Always use a spacer for inhalers/puffers
- ☆ Know how much medication is left in your inhaler
- ☆ Have a plan to refill medications each month
- ☆ Keep your medication in a safe place, away from small children
- ☆ Rinse your mouth after using inhaled controller medications



From One Minute Asthma © Pedipress, Inc. www.pedipress.com

### Peak Flow Chart

***Children over the age of six may be given peak flow meters to monitor their asthma. Parents of children under age six should use symptoms to determine the child's zone.***

**Personal Best Peak Flow_____ Date_____**

| Personal Best- 100% | 100 | 110 | 120 | 130 | 140 | 150 | 160 | 170 | 180 | 190 | 200 | 210 | 220 | 230 | 240 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yellow- 80% | 80 | 90 | 95 | 105 | 110 | 120 | 130 | 135 | 145 | 150 | 160 | 170 | 175 | 185 | 190 |
| Red- 50% | 50 | 55 | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 | 100 | 105 | 110 | 115 | 120 |

| Personal Best- 100% | 250 | 260 | 270 | 280 | 290 | 300 | 310 | 320 | 330 | 340 | 350 | 360 | 370 | 380 | 390 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yellow- 80% | 200 | 210 | 215 | 225 | 260 | 240 | 250 | 255 | 265 | 270 | 280 | 290 | 295 | 305 | 310 |
| Red- 50% | 125 | 130 | 135 | 140 | 145 | 150 | 155 | 160 | 165 | 170 | 175 | 180 | 185 | 190 | 195 |

| Personal Best- 100% | 400 | 420 | 440 | 460 | 480 | 500 | 520 | 540 | 560 | 580 | 600 | 620 | 640 | 660 | 680 | 700 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yellow- 80% | 325 | 335 | 350 | 370 | 385 | 400 | 415 | 430 | 450 | 465 | 480 | 495 | 510 | 535 | 545 | 560 |
| Red- 50% | 200 | 210 | 220 | 230 | 240 | 250 | 260 | 270 | 280 | 290 | 300 | 310 | 320 | 330 | 340 | 350 |

**For more copies of this form contact The Vermont Department of Health, PO Box 70, Burlington, VT 05402, 1-800-439-8550.**

**ASTHMATIC ACTION PLAN**

***Protocol for Delegating the Administration of an Inhaler to Non-Medical School Personnel***

**FOR: student (DOB)**

**Peak Flow Scale**
**240 = personal best**
**190 = 80% of personal best**
**120 = 50% of personal best**

**Peak flow readings (Take three readings highest counts)**

**240 – 195 = OK – doing well**
**190 – 125 = Caution – give Albuterol and notify parents**
**120 – below = Emergency - medication needed now, call 911 & parents**

**Phone #** **Parents – _____**
**Doctor – _____**

**I. Signs of asthmatic attack**

**a.** Changes in breathing - **peak flow 190 - 125**, wheezing, shortness of breath, huffing and puffing after minimal exercise, flared nostrils, coughing,

**b.** Verbal complaints and actions – "My chest hurts or is tight." "I can't catch my breath."

**c. IF THE FOLLOWING HAPPENS, GET EMERGENCY HELP NOW!**
Signs and symptoms: **peak flow of 120 or below**, skin pale color, purple lips, chest and shoulders pulled up struggling to breath, pulling in of skin between ribs with attempts to force air into lungs.

**II. Steps for acute asthmatic attack**

**a.** At peak flow reading **190 - 125** administer Albuterol inhaler 2 puffs one minute apart every 4-6 hrs. as needed.

**b.** After 20 min. check peak flow - if **190-125** call (1) parent or (2) MD if parent unavailable

**c.** If **peak flow is 120 or below**, breathing continues to worsen after steps a & b above, or the above emergency symptoms in part I c appear **call Emergency Medical System - 911 and parents. If you have not given Albuterol already, give immediately.**

Approved by: _____, MD

_____School Nurse
Associate School Nurse

This protocol can only be carried out by the school nurse/associate school nurse and those school personnel trained and delegated by the school nurse to give medications.

## INDIVIDUAL MEDICATION LOG

NAME: _____ GRADE/CLASS: _____
PRIMARY CARE PROVIDER: _____ TEACHER: _____

MEDICATION: _____

DOSAGE AND TIME ADMINISTERED: _____

DRUG INFORMATION:

1. USE: _____

2. SIDE EFFECTS: _____

3. DRUG INTERACTIONS: _____

4. USUAL DOSE: _____

INITIAL/SIGNATURE_____

| DATE/TIME | DATE/TIME | DATE/TIME | DATE/TIME | DATE/TIME | DATE/TIME |
|---|---|---|---|---|---|
| | | | | | |
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MEDICATION RECORD: ADMINISTRATION--PHYSICIAN'S ORDER
SCHOOL, , VERMONT

School Year:_____

Student:_____ DOB:_____ Teacher:_____ Room:_____

Medication, Route:_____ Physician:_____ Phone:_____

Date, Dose, Time:_____ Physician Address:_____

Date, Dose, Time:_____ Comments:_____

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| August | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| September | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| October | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| November | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| December | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| January | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| February | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| March | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| April | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| May | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| June | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

INITIAL NAME

_____ _____

_____ _____

_____ _____

CODES

_____ = WEEKEND F= FIELD TRIP H = HOLIDAY

D = EARLY DISMISSAL W = DOSE WITHHOLD O = NO SHOW

A = ABSENT N = NONE AVAILABLE

# MENTAL HEALTH

## STATEMENT OF PURPOSE:

School health services shall be a part of a comprehensive approach to caring for students with mental health issues.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 99 § 2902 - Education support system
- 33 V.S.A. Chapter 43 § 4305 – Coordinated system of care

## DEFINITION:

**Mental health issues and illness of children and youth may include:**

- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- Anxiety Disorders
- Mood Disorders
- Suicide attempts
- Eating Disorders
- Substance Abuse
- Aggressive, disruptive or violent tendencies
- Conflicts regarding sexual identity
- Self-harm cutting
- Post traumatic stress disorder
- Obsessive-compulsive Disorder
- Oppositional Deficit Disorder

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

Act as a resource for:

1. Assessment, intervention and follow-up of students, as well as for identifying existing and emerging mental health needs that affect school success.
2. The educational support team and crisis intervention teams.
3. Health care providers and family to optimize treatment plans.

## RESOURCES:

- AAP Mental Health in Schools Statement - http://aappolicy.aappublications.org/cgi/reprint/pediatrics;113/6/1839.pdf
- Achenbach Child Behavior Checklist for Ages 6-18 and Teacher's Reporting Form for Ages 6-18
- Children and Adults with Attention-Deficit (CHADD) /Hyperactivity Disorder - www.chadd.org
- Connors' Teacher Rating Scale and Parent Rating Scale

- Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV), published by the American Psychiatric Association, Washington D.C., 1994
- National Association of School Nurses (NASN) - www.nasn.org
- National Mental Health Association (NMHA) - www.nmha.org

## SAMPLE POLICIES, PROCEDURES AND FORMS

Vermont Multidisciplinary Approach to the Assessment and Treatment of School Aged Children with Symptoms of Attention Deficit Hyperactivity Disorder

# Vermont Multidisciplinary Approach to the Assessment and Treatment of School-Aged Children with Symptoms of Attention Deficit Hyperactivity Disorder

*Families, Educators, Physicians and other Professionals Working Together on Behalf of the Child*

## Introduction:

In March 2003, the Vermont Department of Health (VDH) and Vermont Child Health Improvement Program (VCHIP) convened a summit meeting on Attention Deficit Hyperactivity Disorder (ADHD). The objective was to discuss the topic of ADHD especially as it applies to Vermont children and to consider adopting the ADHD Toolkit, developed and copyrighted in 2002 by a joint venture of the American Academy of Pediatrics (AAP), National Initiative for Children's Healthcare Quality (NICHQ) and McNeil Pharmaceuticals, as the Vermont ADHD assessment standard. At the conclusion of that meeting, it was clear that participants were not ready to adopt the NICHQ Toolkit without further consideration. There was consensus, however, that it would be desirable to have a standardized approach to how we assess, and treat Vermont school-aged children with symptoms of ADHD.
Subsequently, a working group comprised of 25 individuals representing 12 domains including: Department of Education (DOE), Vermont Department of Health (VDH), Department of Developmental and Mental Health Services (DDMHS), VCHIP, Parent to Parent, Vermont Parent Information Center (VPIC), parents, special educators, school psychologists, psychiatrists, pediatricians, and neurophysiologists met three times. The group agreed with the basic premise: the desirability of having a standardized approach to the assessment, and treatment of school-aged children with symptoms of ADHD. Furthermore, it was considered critical that families, educators and medical professionals work collaboratively to develop this system.

The products of the ADHD working group include:

- a *detailed* flow chart which maps the multi-disciplinary approach to the assessment and treatment of school-aged children with symptoms of ADHD
- an *abbreviated* flow chart which is a simplified version of the detailed flow chart
- an *educational* narrative which describes more specifically the educational components involved in the detailed ADHD flow chart (right hand column in green)
- a *medical* narrative which describes more specifically the medical components involved in the detailed ADHD flow chart (left hand column in blue)
- a *family/caregiver* narrative which describes in detail the family/caregiver components of the detailed ADHD flow chart (central column in yellow)

**The products of the working group are described in the following narratives. Please refer to the three separate narratives, medical, educational and family/caregiver, for a comprehensive description of the attached ADHD flow charts.**

The **title** was developed to clearly state the intent and importance that this work be collaborative in nature. It is meant to foster a sense of partnership between families, educators, medical and other professionals in the assessment of school-aged children with symptoms of ADHD. It is our hope, that in the future, a similar flow chart will be developed for preschool-aged children with symptoms of ADHD.

The **asterisk [*]** alerts the reader to the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM IV™) classification of ADHD into three (3) subtypes: Predominantly Inattentive Type,

Hyperactive – Impulsive Type, and Combined Type. Previous nomenclature such as Attention Deficit Disorder (ADD), Hyperactivity Disorder, etc, is subsumed in the current classification.

The boxes are **numbered** purely for ease of reference. Numbering does not imply importance, nor does it indicate a rigid sequence. For example, Box 2 does not necessarily come before Box 3 or Box 4.

The **arrows** depict lines of communication that are essential in understanding and using the flow charts.

**Medical Narrative**

**BOX 1. *INITIAL ASSESSMENT TRIGGERED BY*:** An initial assessment can be triggered by concerns in any or all (or any combination) of 5 areas: distractibility, impulsivity, hyperactivity, behavioral or social problems or academic underachievement. Concerns may arise from any source, however, the family / caregiver, school personnel or medical professionals are the usual sources.

**BOX 3. *INITIAL MEDICAL CONSULTATION**:** The asterisk [*] indicates that this consultation usually requires more than one interaction.

- The pediatric Primary Care Provider (PCP) should explain the assessment and evaluation process for students with symptoms of ADHD.
- Tools that can be used include the *detailed* flow chart, the *abbreviated* flow chart or any other instrument that conveys similar information.
- At the initial visit, it is appropriate to begin to implement Box 4: "Beginning of Dialogue about Advocacy, Collaboration and Information Sharing Between Family / Caregiver and School, Healthcare Provider, and / or Others.**"** A discussion of the importance of working together as a team is often helpful in setting a positive tone. It is important to be aware that not every family will be ready for this kind of sharing initially. A written consent form must be obtained when information sharing is desired.
- The primary care provider obtains a medical history and full "review of systems" (ROS). This provides detailed medical background information that is pertinent to the evaluation. The ROS includes information about the child's birth, development, temperament, medications, allergies, family and social history, and a systematic review of each body system (e.g. central nervous system, respiratory, cardiac, gastrointestinal, etc.).
- Parent and School Information: The VT ADHD working group recommends use of a DSM IV™ based tool for the diagnosis of ADHD *combined with* an instrument which identifies the presence of a broad range of symptoms. This will assist PCPs in screening children for co-morbid conditions.

Tools specifically designed to detect the DSM IV™ criteria for ADHD:

ADHD Rating Scale IV. This instrument closely approximates symptom criteria for ADHD. Parent and teacher versions provide a brief (18 item) checklist of symptoms. Analysis of symptoms by age and gender provides developmentally sensitive cut-off scores that make this instrument appropriate for screening and diagnostic assessment. Caution should be used with African American children and using this scale for treatment monitoring. The booklet must be purchased and entitles the user to make as many copies as desired. [ISBN 1-57230-423-5]

Conners' Rating Scale-Revised. This scale has parent, teacher and adolescent questionnaires in Long Form (59-87 item) and Short Form (27-28 item) versions. These well-validated questionnaires do not mirror symptom criteria for ADHD but have other benefits. The Long Form is a useful diagnostic assessment instrument that taps a broad range of emotional disorders. The Short Form is a good screening instrument that is sensitive to treatment effects and can be used for monitoring.

ADHD Symptom Checklist-4. This checklist closely approximates symptom criteria for ADHD and ODD with additional items on aggression and a checklist of stimulant side-effects. Parent and Teacher Forms (50 item) can be recommended for screening purposes and are highly recommended for monitoring treatment effects, especially stimulant medication.

NICHQ Vanderbilt Assessment Scale Parent and Teacher Informant (initial assessment and follow-up assessment). This assessment scale provides Parent (55-item) and Teacher (43-items) measures of symptoms of ADHD, common co-morbid conditions (Oppositional Defiant Disorder, Conduct Disorder, Anxiety and Depression), and broad measures of functioning. A more brief follow-up form monitors ADHD symptoms, academic performance and common medication side effects. The Vanderbilt Assessment Scale is available free at the NICHQ website. These forms are NOT normed for age or gender and evidence of its' discriminate validity is insufficient.

It is recommended that all ADHD checklists be validated instruments, based on an assessment of the DSM-IV™ criteria for ADHD.

In addition to assessing ADHD symptoms, it is essential to screen for possible symptoms of co-morbid conditions. We recommend using an instrument such as the Achenbach Child Behavior Checklist which screens for a broad range of symptoms.

The **Achenbach Child Behavior Checklist (CBCL)** is an empirically derived instrument normed for age and gender. This instrument can be used over time to assess changes in symptom presentation. There are Parent and Caregiver/Teacher Forms for children age 18 months to adult. Youth Self-Report Forms are available for age 11 to adult. The CBCL is well validated and widely used nationally and internationally. It is available in a paper version and as a web-based system.

If suspicion of co-morbid conditions is raised, the PCP can refer to the ADHD Resource List (attached).

- Information from school: It is vital to have accurate information from school. It provides an opportunity to highlight the student's strengths, and provides documentation about behaviors which interfere with function in the school setting. This ensures that co-morbid conditions such as learning disability, anxiety, depression etc. will be considered from the outset. The school psychologist may be involved in this process as well.

- Information from school regarding student strengths, school history, academic profile, behavioral and academic concerns, educational strategies, modifications and accommodations already provided or tried, etc. can be obtained from school using the instruments entitled: Student Information Form (Grades K-6) and Student Information Form (Grade 7-12).

**BOX 8.** ***FOLLOW-UP MEDICAL VISIT:*** Following review of all the above, it is essential to meet with the family again to discuss the findings and develop an appropriate treatment plan.

- If the student meets the criteria for ADHD, advance to Box 9.

**BOX 9.** ***DEVELOPMENT OF A MULTIMODAL ADHD TREATMENT PLAN:*** Discussion and development of a multimodal ADHD treatment plan includes:

- Child/family/caregiver education: Education regarding ADHD promotes understanding, patience and empathy as well as offering an opportunity to develop creative, family-specific strategies for success. Individuals might consider the Vermont Parent Information Center (VPIC) and/or Parent

to Parent of Vermont (See ADHD Resource List) for additional information and support for families/caregivers.

- Instructional modifications, accommodations and supports in school and at home: This may be informal or involve a specific 504 Plan or an Individualized Educational Program (IEP) through the services of the Special Education Department.
- Behavioral treatment: This may involve developing/maximizing the child's coping strategies, personal strengths, addressing social skills issues, time management and organizational skills, strategies for dealing with frustration, anxiety, feeling overwhelmed etc.
- Family/caregiver and or child counseling: Individual and/or family counseling can be helpful in addressing behavioral issues, parent/child conflicts, socia l skills issues, anxiety management strategies, parenting difficulties etc.
- Medication: Research has clearly demonstrated that medication can be very helpful in treating the core symptoms of ADHD: inattention, impulsivity and hyperactivity. The PCP needs to schedule regular medication monitoring visits with the child and family and have ongoing communication/collaboration with school personnel. This is necessary to assess the benefits and possible side effects of medication treatment.
- Parents, school personnel and the PCP should collaborate in order to identify ADHD target symptoms and develop an individualized ADHD treatment plan.
- When indicated, the PCP should provide a summary letter for school regarding the treatment plan proposed.

- If the student does NOT meet the criteria for ADHD, but meets criteria for another diagnosis, advance to Box 14**.**

**BOX 14.** ***DEVELOPMENT OF APPROPRIATE TREATMENT PLAN:*** Develop an appropriate treatment plan for that condition.

- If the student does NOT meet the criteria for ADHD or another disorder, advance to Box 13.

**BOX 13.** ***ONGOING EVALUATION OF CHILD'S*** **Function, Symptoms, Strengths, Response to treatment**: Pursue ongoing monitoring.

**BOX 5.** ***ONGOING ADVOCACY, COLLABORATION AND INFORMATION SHARING WITH FAMILY / CAREGIVER:*** This communication should take place regularly during the evaluation process and follow up.

**BOX 11.** ***FAMILY/CAREGIVER ARE AWARE OF AND INVOLVED IN TREATMENT PLANS:*** Treatment plans should be constructed using all available information. Plans should utilize and maximize the student's personal strengths. Plans should be a collaborative effort of all parties.

**Family/Caregiver Narrative**

**BOX 1.** ***INITIAL ASSESSMENT TRIGGERED BY:*** This box lists the types of concerns that would prompt a parent or caregiver, school personnel, or physician to seek further assessment for the child. If families/caregivers are the first ones to have concerns about the child, a good first step is to bring these concerns to the classroom teacher or other school personnel and the child's health care provider. As noted in the educational narrative for Box 6, if a parent/caregiver or teacher believes the child has a disability and is in need of special education, the parent may make a direct referral to the special education administrator at any point in the process.

**BOX 4.** ***BEGINNING OF DIALOGUE ABOUT ADVOCACY, COLLABORATION, AND INFORMATION SHARING AMONG FAMILY/CAREGIVER, SCHOOL, HEALTHCARE PROVIDER AND/OR OTHERS:*** It is important for all parties involved in the assessment of a child who has symptoms of ADHD to recognize that a high quality, comprehensive assessment is a process. This process requires collecting and analyzing a wide range of information to make an accurate diagnosis. The Vermont Department of Education recognizes that psychologists and physicians can make the diagnosis of ADHD in order to provide appropriate school services. The medical diagnosis of ADHD is usually made by a physician. All of these professionals use a standard set of criteria contained in the contained in the Diagnostic Statistical Manual (DSM-IV) to make the diagnosis. These criteria assess whether the child has significant difficulties with distractibility, impulsivity, and hyperactivity. Additionally, the difficulties must represent a significant, longstanding impairment in functioning in two or more settings.

Families/caregivers come to the assessment process at different stages of readiness to share information about their child and family. There are many reasons why families/caregivers might hesitate to share information about their child. Some families/caregivers fear an assessment for ADHD means the child will be "labeled" and automatically prescribed medication. Families/caregivers may also feel certain information is too sensitive to share and feel their privacy is threatened. They may also wonder why such information is necessary to share during the assessment. Professionals involved with the assessment process should exercise sensitivity regarding family/caregiver concerns.

The Vermont Parent Information Center (VPIC) has developed two fact sheets, "How Families and Professionals Can Build Winning Partnerships" and "How Parents Can Communicate Effectively with Professionals". These handouts (attached) offer suggestions for families/caregivers and professionals on ways to develop a productive working relationship on behalf of the child.

In order for health care providers, school and other professionals involved in the assessment to share information about the child with each other, a written consent from the child's family/caregiver, specifying the types of information to be shared, is required.

Families/caregivers are the experts when it comes to their own children. The bulleted items in this box list some types of information families/caregivers can expect to be asked to share with the primary health care provider, school personnel or the school psychologist, in the course of an assessment for ADHD.

- Families'/caregivers' (and child's, when appropriate) concerns, goals, and ideas
- Child's strengths and interests
- Family make-up (such as other siblings, children adopted; parents married, single, divorced, widowed, etc)

- Prenatal and birth history (such as information about the length of the pregnancy, any complications with the child's birth)
- Child's development (such as language development, when the child walked) and
- temperament (such as "easygoing" or "slow to warm up")
- Child's medical history (such as significant illnesses, hospitalizations, surgeries, substance abuse)
- Extended family history (such as medical history, history of school or learning problems, substance abuse)
- Family stressors and/or traumas (such as a recent move, the death of a loved one or other loss, substance abuse, an accident or serious injury, or stressful home environment).
- Child's school performance, past and present
- What has been tried to support the child? (this can include things that have been tried at home, in school or other settings)
- What works and what does not work for the child? (What types of environments or activities does the child do best with and what types of environments or activities are challenging for the child?

The primary care provider may already have valuable information such as prenatal and birth history, medical and developmental history. Families/caregivers may be asked to complete a form with some of the information noted above prior to an appointment.

**BOX 5.** ***ONGOING ADVOCACY, COLLABORATION AND INFORMATION SHARING WITH FAMILY/ CAREGIVER*****:** Families/caregivers also have an important role as their child's advocate. An advocate looks out for the child's interest and makes sure the child gets an appropriate assessment and services. The VPIC handout "Advocating for Your Child" provides a brief introduction to help families/caregivers advocate for their child. Family/caregivers might also consider contacting VPIC (See the ADHD Resource List for contact information) for more information and support in advocating for their child. Parent to Parent of Vermont (See ADHD Resource List for contact information), is another statewide organization that helps families/caregivers of children with special needs find support from other parents, healthcare professionals and the community.

**BOX 11.** ***FAMILY/CAREGIVER IS AWARE OF AND INVOLVED IN TREATMENT PLANS*****:** If a diagnosis of ADHD has been made, a treatment plan needs to be developed. Families/caregivers (and child, if appropriate) school staff, and the primary care provider should all participate in the development of this plan. The treatment plan should meet the child's and the family/caregiver's concerns and needs and take advantage of the child's strengths, interests, learning style, temperament, and developmental level. If medication is part of the treatment plan, it must be prescribed and monitored by a medical professional licensed to dispense medications. The treatment plan should also include regular exchanges of information between families/caregivers and other team members. If the child is found eligible for special education, the family/caregiver has rights that ensure a regular exchange of information between the family/caregiver and the school.

For instance, the family/caregiver must be invited to participate in the development of an Individualized Education Program (IEP), which is a written plan for a child that describes the special education and related services a child will receive if eligible for special education. Families/caregivers will receive notification of all meetings for this IEP development. Based on the federal Individuals with Disabilities Education Act (IDEA) and the Vermont Department of Education's Special Education Regulations, families/ caregivers can expect to receive information

from the school that describes their rights in special education. The Vermont Parent Information Center (VPIC) offers two helpful fact sheets entitled “Parents’ Rights in Special Education” and “The Individualized Education Program (IEP)” which are attached.

For children determined to have a disability, but who are not eligible for special education services, they may be found eligible for accommodations and/or services under Section 504 of the Rehabilitation Act. Families/ caregivers are also part of the development of the 504 Plan. Families can still benefit from learning about how to advocate for being included as a regular member of the team and in the exchange of information. This will serve to update information collected during the assessment and to help determine the child’s response to the various interventions and/or changes in other areas that might affect this response. The VPIC fact sheet “What You Need to Know About Section 504” (attached) is a helpful resource on Section 504.

**Educational Narrative**

**BOX 2.** ***INITIAL EDUCATIONAL INTERVENTIONS*****:** At any point, as a student experiences difficulties with any of the five symptoms of ADHD (distractibility, impulsivity, hyperactivity, behavioral or social problems, or academic underachievement) in the classroom setting, it is expected that the classroom teacher would provide interventions specially designed to meet the needs of the student. To accomplish this, all classroom teachers need training on providing accommodations and modifications to classroom routines for students with intentional problems. Included in these accommodations and modifications will be communication with families/caregivers and school staff with particular expertise in this area. If the teachers' accommodations or modifications do not adequately address the student's needs, the teacher will then refer to the Educational Support Team (EST).

**BOX 6.** ***REFERRAL TO EDUCATIONAL SUPPORT TEAM (EST):*** The EST exists in each school and consists of a variety of school staff (administrator, school counselor, behavior specialist, nurse, special educator, classroom teachers) that meet regularly to discuss student needs and help create plans for students at risk. Many students with attentional issues are likely to be referred to this team for help from teachers and support staff in understanding and planning to meet the student's needs.

- Planning at this level requires data collection and, minimally, informal evaluation of student's learning profile. Included in EST plans are designs for further data gathering as well as immediate interventions. If, over time, these interventions do not result in improved performance, this team may consider a referral for a special education evaluation. This referral is made if there is reason to believe that the student is disabled and in need of special education.

Note: If a parent/caregiver or teacher believes the child has a disability and is in need of special education, the parent may make a direct referral to the special education administrator.

**BOX 7.** ***REASON TO BELIEVE THAT STUDENT IS DISABLED AND IN NEED OF SPECIAL EDUCATION*****:** The special education evaluation process is clearly defined by state and federal regulations. The evaluation and planning process is accomplished in two basic steps.

With family/caregiver participation, a plan for comprehensive evaluation is designed to identify areas of concern and outline evaluation procedures for determining the student's skills and challenges in each identified area as they relate to the educational environment. These areas include the basic academic skills in reading, math and writing, and motor skills. Once parental consent is obtained, the evaluation will be conducted within 60 days. For students with suspected ADHD, a physician, and when appropriate, a school psychologist, should play an active role. A student is determined to be eligible for special education if the team identifies an adverse effect on acquisition of basic academic skills.

A student's eligibility for special education is based on the following:

1. The presence of a disability
2. If there is a disability, whether it has an adverse effect on educational performance in one or more of the basic skill areas, and if 1 and 2 are present,
3. Whether the student needs special education services to benefit from his or her educational program and that this support cannot be provided through the educational support system, standard instructional conditions or supplementary aids and services provided in the school.

- If a student is found eligible for special education, an individualized educational program (IEP) is written by the team. This plan details the student's present levels of performance, annual goals and objectives to meet the student's learning needs, and special education services to be provided by the school. The IEP is updated annually and a reevaluation of special education eligibility occurs at least once every three years.

If the student is found not eligible, the team will provide recommendations to the classroom teacher and parent/caregiver for continued interventions.

**BOX 10.** ***IMPLEMENTATION OF IEP OR 504 PLAN:*** For students eligible for special education, the IEP is implemented. Ongoing assessment of identified educational goals informs the team as well as other health care professionals involved in related aspects of the student's life. This may include the family physician or other medical professionals.

- Occasionally, students are not determined to be eligible for special education even though they have been diagnosed with ADHD. For these students, accommodations that will provide equal access to school activities are usually outlined in a plan format as described in The Vermont DOE booklet *Section 504 of the Rehabilitation Act of 1973 and Vermont Schools* (11/2002), which includes a section on ADHD.

**BOX 12.** ***ONGOING COLLABORATION AND MONITORING OF STUDENT PROGRESS*****:** At any of the previous levels of intervention, appropriate school personnel are available to interact with family and medical personnel in order to provide ongoing monitoring of student progress. The lead individual for the school may be any of the following:

- Classroom teacher
- Building administrator
- Educational support team coordinator
- School guidance personnel
- Nurse
- Special education case manager
- Section 504 case manager

# NUTRITION

## STATEMENT OF PURPOSE:

All schools should establish nutritional practices and policies that support optimal health outcomes for students.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 27 § 1261-1265 – Food programs
- 16 V.S.A. Chapter 5 § 216 – Wellness program
- 7 CFR, Part 210 § 10 – National school lunch program

## SUGGESTED SCHOOL NURSE ROLES:

In collaboration with administrators, guidance personnel, food service personnel, health educators and classroom teachers:

1. Provide age-appropriate and culturally sensitive instruction to help students develop the knowledge, attitudes and behaviors to adopt and maintain healthy eating habits.
2. Write polices ensuring all foods and beverages available on the school campus and at school events contribute toward healthy eating patterns.
3. Chair a School Health Team, examine nutritional practices and develop policy.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Provide information to parents, faculty and students about healthy nutritional practices and risk factors for obesity and eating disorders.
2. Participate on a school health action team to develop a healthy nutrition practices throughout the school setting.

## RESOURCES:

- Action for Healthy Kids - www.ActionForHealthyKids.org
- American Cancer Society - www.cancer.org
- American Heart Association - www.americanheart.org
- Centers for Disease Control and Prevention - www.cdc.gov/HealthyYouth/nutrition/index.htm
- Child Nutrition Programs - http://www.state.vt.us/educ/nutrition/
- NOFA, VT FEED program - www.nofavt.org/programs/vtfeed.php
- USDA Wellness Policy Guidelines - http://www.fns.usda.gov/tn/Healthy/wellnesspolicy.html
- Vermont Department of Health - http://www.healthyvermonters.info/
- Vermont Health Education Resource Centers - http://www.state.vt.us/educ/new/html/pgm_coordhealth/herc/herc.html

## SAMPLE POLICIES, PROCEDURES, AND FORMS:

Department of Education Draft Model Policy Guidelines on Nutrition and Fitness

DRAFT

# Nutrition and Fitness Policy Guidelines

(Pursuant to Act 161 of the 2004 Vermont Legislative Session)

DRAFT

**STATE OF VERMONT**

September 2005

Dear Fellow Vermonter:

The enclosed document, *Nutrition and Fitness Policy Guidelines*, is the result of the collaboration between the Agency of Agriculture, Food and Markets and the departments of Education and Health as required by Act 161 of the 2003 Vermont Legislature session. It is available online at www.state.vt.us/educ/new/html/resources/model_policies.html.

Our goal in publishing these guidelines is to reduce child and adolescent obesity and improve the health of students by providing schools with the most recent information on best practices for school nutrition and physical fitness. The guidelines are based on the recommendations of nationally recognized authorities, including the Surgeon General of the United States, the National Association of State Boards of Education and the National Alliance for Nutrition and Activity. However, many of the recommendations would be costly to implement and go beyond current Vermont public school requirements. For example, the guidelines recommend 150 minutes of physical education per week for students K-8. Aside from the cost implications, many Vermont elementary or middle schools would find it difficult to fit this amount of physical education into their schedule. Nevertheless, we feel it is important for Vermont school leaders to be aware of what the U.S. Department of Agriculture, the Centers for Disease Control, and the U.S. Department of Health and Human Services are saying is necessary to reduce obesity and improve physical well-being.

In the coming year, all schools participating in the National School Lunch Program will be required to adopt a school wellness policy. The Vermont School Boards Association will develop a model school wellness policy which will meet the minimum requirements of the federal legislation. We recommend that school districts use the *Nutrition and Fitness Policy Guidelines* to enhance the language of their wellness policy. Their policy should also reflect the mission of the school and availability of resources to support expanded health, physical activity and nutrition programs.

We intend to update this document online as relevant new information becomes available. You may send your comments to shevonnetravers@education.state.vt.us.

Sincerely,

Steve R. Kerr, Secretary
Agency of Agriculture,
Food and Markets

Richard H. Cate, Commissioner
Department of Education

Paul E. Jarris, MD, MBA
Commissioner
Department of Health

The Vermont Department of Education in collaboration with
Department of Health and Agency of Agriculture, Food & Markets

# Nutrition and Fitness Policy Guidelines

## Introduction

Vermont's Nutrition and Fitness Policy Guidelines were developed by representatives from the Department of Education, Department of Health, Agency of Agriculture, and Vermont educators. The guidelines are divided into five sections:

1. Nutrition
2. Physical Education
3. Physical Activity
4. Implementation
5. Reporting to the Community

The purpose of this document is to provide guidance for district policy writers. This document is intended for use by districts drafting their own policies. The concepts represent the best practices available today and are reflective of the highest standards to which schools should aspire.

The Guidelines are based on the following:

- In order for children to achieve their full academic potential, healthy-eating patterns are essential. A well planned and well implemented school nutrition program positively influences students' eating habits. Consuming a variety of nutritious foods promotes healthy growth and development and provides the necessary energy for learning.

- A comprehensive physical education program, coupled with moderate to vigorous physical activity on a daily basis, has been shown to improve student learning and well-being. Quality physical education programs positively impact students' physical, social and emotional health. The goal of physical education is to instill a passion for lifelong physical activity. This is accomplished by incorporating a variety of programs in the curriculum.

# I. Nutrition

## A. Nutritious Food Choices

1. Nutritious foods are available wherever and whenever food is sold or otherwise offered at school.

2. See Appendix A for the definition of nutritious foods.

## B. The School Food Service Program

1. Menus are planned to conform to the Dietary Guidelines for Americans and the nutrient standards established in the regulations of the National School Lunch Program (7CFR 210) and the School Breakfast Program (7CFR 220).

2. A la carte (see Appendix A for definition) foods conform to the a la carte guidelines outlined in Appendix B.

3. Food pricing strategies are designed to encourage students to purchase nutritious items and/or reimbursable meals.

4. Compatible with federal regulations for such purchases, the food service program establishes procedures to include locally grown foods and beverages in the development of purchasing bids or procedures. Procedures to promote the purchase of locally grown products may include:

    a. purchasing partnerships with local farms and farmers, manufacturers, and small processors;
    b. taking advantage, where possible, of local products that are already available through distributions channels in the state such as eggs, milk and dairy products, apples, and other produce;
    c. asking local distributors to carry Vermont products in their inventory to allow for easier availability to schools; and
    d. writing bid contracts that allow districts to buy local products "off bid" if primary vendors cannot or will not sell them.

## C. Other Food Choices at School

1. Foods and beverages available at school support the nutritional needs of students, are nutritious and meet the A la Carte Guidelines outlined in Appendix B.

2. All food sales on school grounds are under the management of the school food service program. Nutritious foods are included at any time foods are sold at school to raise funds.

3. Foods sold through vending machines conform to the Vending Guidelines outlined in Appendix C. No foods are sold from vending machines during meal service times.

4. To the extent possible, foods sold in vending machines, school stores, snack bars, and other venues are purchased using the practices described above regarding locally grown foods.

D. Promoting Healthy Eating Behaviors

1. Students and staff have adequate space to eat meals in pleasant surroundings and adequate time to eat, relax, and socialize. At a minimum, lunch periods are at least 20 minutes long. Sufficient transition time is also provided.

2. Nutrition education is integrated within the health education program. Nutrition education focuses on developing healthy eating behaviors, is based on theories and methods proven effective by research, and is consistent with Vermont's health education standard 3.5.

3. To the extent possible, lunch periods are scheduled to follow recess periods (in elementary schools).

4. Food is not used as a reward or a punishment for students.

II. Physical Education Program

A. Instructional Program

1. The physical education program is sequential, developmentally appropriate and, in alignment with the National Association for Sports and Physical Education, a minimum of 150 minutes per week for elementary school students and 225 minutes per week for middle and high school students. The majority of physical education class time is spent in moderate to vigorous physical activity.

2. Classes are taught by licensed physical education teachers.

B. Facilities

1. The school provides a safe environment to implement the program. A safety inspection is conducted annually.

2. The school provides both functional and protective equipment for all students to participate actively and safely.

3. The school minimizes interruptions to scheduled physical education classes. This includes interruptions due to scheduling non-physical education activities in physical education facilities.

C. Curriculum

1. The curriculum uses developmentally-appropriate components of a health-related fitness program, e.g. Fitnessgram, Physical Best, or President's Challenge.

2. The curriculum equips students with the knowledge, skills and attitudes necessary for lifelong physical activity.

3. The curriculum offers students multiple opportunities to prepare for a variety of lifetime physical activities.

4. The curriculum builds students' competencies in their own physical abilities and thus improves their self confidence.

5. The physical education program is closely coordinated with the overall school health program. Physical education topics are integrated within other curricular areas. In particular, the benefits of being physically active are linked with instruction about human growth, development, and physiology in science classes and with instruction about personal health behaviors in health education class.

6. The physical education curriculum and assessments are aligned with standard 3.6 of the Vermont Framework for Standard and Learning Opportunities and with the Vermont Physical Education Grade Expectations.

D. Inclusion (Adapted Physical Education)

1. The physical education program includes all students, unless otherwise contra-indicated medically.

2. Suitable adapted physical education is included as part of Individual Education Plans (IEPs) for students with chronic health problems, other disabling conditions, and other special needs that preclude participation in regular physical education instruction or activities.

3. A student with a chronic health problem or other disabling condition is permitted to participate in any extra-curricular activity, including interscholastic athletics, if the student's skills and physical condition meet the same qualifications as other students. The school makes reasonable accommodations to allow the student to participate.

III. Physical Activity

A. Recess

1. Supervised unstructured active play, commonly referred to as recess is offered daily for all students Pre-K–8. Recess is in addition to a student's physical education class and not substituted for physical education class.

2. Recess and other physical activity shall not be taken away as a form of discipline unless doing so is directly related to a student's behavior during recess.

3. Proper equipment and a safe area is designated for recess.

4. Opportunities are provided for students, in grades 9-12, to be physically active during the school day, in a safe environment, beyond the physical education class. Activities may include open time in the gymnasium, walking programs or aerobic activities.

B. Interscholastic Sports (Athletics)

1. Instruction/coaching is designed to develop sport specific skills that are based on appropriate teaching/learning progressions.

2. Instruction/coaching provides a learning environment that is appropriate to the characteristics of the athletes and goals of the program.

3. Instruction/coaching utilizes a variety of teaching strategies to improve athletic performance and development.

4. Instruction/coaching uses appropriate forms of motivation and provides constructive feedback to athletes.

C. Before and After-School Programs

1. The school works with the community to provide an avenue for reaching all students before and after school through organized physical activities (e.g. intramurals, interscholastic sports, community-based programs, and other activities).

2. Use of the school facilities by community members for physical activities is encouraged.

IV. Policy Implementation

There is a plan for measuring the implementation of the policy, including designation of one or more persons charged with operational responsibility for ensuring that the policy is enforced.

V. Reporting to the Community

A. Report Topics

In reporting nutrition and fitness data, in a format easily understood by the public, the school will be in compliance with state and federal confidentiality laws. Data for the report is available from the following sources:

1. Physical fitness data such as Fitnessgram, Physical Best or the President's Challenge on Physical Fitness

2. Youth Risk Behavior Survey (YRBS) data

3. School Lunch Program data, such as the percentage of students participating in the meals program.

4. Physical Education and athletic program data, such as the percentage of students participating in physical education classes, athletics and intramural sports.

5. Wellness Program data, such as the percentage of students participating in special wellness programs run by the District throughout the year.

6. Health Services Program data, such as the percentage of students with a healthcare and dental provider.

B. Report Mechanism

A report on the health status of students is included in the report the District develops to comply with 16 VSA §165(a) (2) (B).

# Appendix A
# Definitions

A la carte food - A la carte food includes all foods sold by the food service program that are not part of a reimbursable meal.

Intramurals – Competitive and non-competitive programs that are provided *by* the school *for* students enrolled in the school.

Nutritious foods - Nutritious foods are nutrient-dense foods including whole grains; low-fat or non-fat dairy products; fresh, frozen or canned fruits and vegetables; lean meats, poultry, fish, and beans. Nutritious foods exceed the nutrient levels of Foods of Minimal Nutritional Value, which have been identified by the United States Department of Agriculture (7 CFR 210, Appendix B).

Appendix B

## A La Carte Food and Beverage Standards

"A la carte" refers to foods and beverages sold by the food service program in addition to the USDA reimbursable school meals. These food sales are intended to provide students with some additional food choices and to raise revenue to support the school food service program. Studies show that students who consume reimbursable school meals have better overall nutrient intakes than those who consume foods from any other source. A la carte foods are:

- priced to encourage students to select meals rather than a la carte foods;
- limited in quantity and variety; and
- designed to supplement, not replace, school meals.

| Grades K-6 | Standard |
|---|---|
| During Meal Service Periods | Eliminate foods that are sold outside of the breakfast and lunch programs. |
| Snacks and Breaks | If the school offers a morning or afternoon break/snack, individual items sold meet the a la carte food standards. The morning snack or break occurs at least 1.5 hours before the lunch meal. |
| **Grades 7-12** | **Standard** |
| During Meal Service Periods | Limit foods that are sold outside of the breakfast and lunch programs to items that are a supplement to, rather than in competition with, the meal. Entrees that would qualify as a meal component for the reimbursable school breakfast or school lunch program is not available as an a la carte item. Individual items sold meet the a la carte food standards. |
| Beverages | • Juice beverages must contain at least 50% fruit or vegetable juice, and the package size is no larger than 12 oz.<br>• Water shall contain fewer than 20 calories per serving without artificial sweeteners.<br>• Low or nonfat white or flavored milk, or drinkable yogurt shall be offered in portion sizes no larger than 16 oz. and contain no more than 340 total calories. |
| Grains | • Whole grains and naturally occurring grains with minimal amounts of added fat and sugar may be served. Whole grains will have at least 1 gram of fiber per serving.<br>• Other products will contain no more than 5 grams of fat per 1 ounce serving and no more than 2 grams of saturated fat and/or trans fat per 1 ounce serving.<br>• No more than 25 grams of total carbohydrate per serving (includes natural sugar and added sugar).<br>• Portion sizes are limited to 2 oz. for most products, 3 oz. for baked goods such as muffins, pastries and bagels. |

| Grades 7-12 | Standard |
|---|---|
| Dairy Products Other Than Milk | • Regular cheese – portion size no larger than 1½ oz.<br>• Reduced fat cheese – portion size no larger than 2 oz.<br>• Yogurt – portion size no larger than 8 oz.<br>8 oz. should be equal to or less than 200 calories per serving<br>6 oz. should be equal to or less than 150 calories per serving<br>4 oz. should be equal to or less than 100 calories per serving<br>• Frozen desserts, including ice cream, are limited to a portion size of no more than 3 oz. |
| Fruits and Vegetables | • If any foods are sold a la carte, fresh, frozen, canned and/or dried fruits and vegetables will be available as well.<br>• Portion sizes for fried vegetables (french fries, onion rings, for example) will be ½ cup or less, and no larger than the portion of the same vegetable served in the school lunch program. |
| Meat, Beans, and Nuts | • Total fat – no more than 5 grams of fat per 1 ounce serving with the exception of nuts, seeds, and nut butters.<br>• Saturated fat and trans fat – no more than 2 grams per 1 ounce serving<br>• Portion sizes are limited. For example: trail mix, nuts, seeds, jerky – no larger than 2 oz. |

Background

Grade K-6:
The rationale for the elementary school recommendation is that young children should only be presented with opportunities to make healthy food choices at school and healthy choices should be modeled throughout the school environment.

Sugar:
Excess sugar adds unnecessary calories to the diet and contributes to tooth decay. This includes added sugars that do not naturally occur in food. Added sugars are sugars and sweeteners (white, brown, and raw sugars; fructose, honey, molasses, anhydrous dextrose, and crystal dextrose), and syrups (corn, malt, pancake, maple, and high fructose corn). Naturally occurring sugars present in milk and fruit, such as lactose and fructose are not considered added sugars.

Fats:
Higher intakes of saturated and trans fats, and dietary cholesterol raise low density lipoprotein (LDL or "bad") cholesterol in the blood. An elevated LDL cholesterol increases the risk of developing coronary heart disease (CHD). To decrease LDL cholesterol and the risk of CHD, substitute monounsaturated and polyunsaturated fats for saturated and trans fats and decrease the intake of cholesterol. Trans fat can be found in vegetable shortenings, some margarines, crackers, candies, cookies, snack foods, fried foods, baked goods, and other processed foods made with partially hydrogenated vegetable oils. Small amounts of naturally occurring trans fat can be found in some animal products, such as butter, milk products, cheese, beef, and lamb. Labeling of trans fats on food labels will be required starting January 1, 2006.

Sodium:
Schools should be aware of the sodium content of foods served and sold. According to the FDA foods labeled healthy must contain less than or equal to 360 mg per serving for an individual food and 480 mg per serving for meal-type products.

Caffeine:
Caffeine is a central nervous stimulant that in children may cause nervousness, anxiousness, fidgetiness or other similar behaviors. FDA requires that caffeine be listed on ingredient labels although herbal forms may not be recognized as caffeine sources. Herbal products containing kola (cola or kola nut), cacao (cocoa), guarana, mate, and green tea are known sources of caffeine.

Beverages:
Beverages are included that provide nutritional value. Fruit and vegetable juices contain a variety of nutrients including Vitamin C; low fat and nonfat milk include calcium and Vitamin D and Vitamin A, while not adding excess calories from fat; water without added ingredients provides hydration without any calories. Flavored milks may be offered as long as they are low or non-fat and do not contain excess calories from added sugar. If soy beverages are sold they must be fortified with Vitamin A, Calcium and Vitamin D to a level equivalent to cow's milk, other dairy alternatives of low nutritional value are not recommended. Serving sizes are limited to reduce consumption of excess calories. According to the food guide pyramid serving sizes are 6 oz. for fruit juices and 8 oz. for milk.

Snacks:
Recommendations for snacks include those that are lower in calorie and contain nutrients. For all foods ingredient labels list items in the order of highest content in the food. If sugar or fat is listed first or second it is more likely that the item contains little nutritional value. Nuts and seeds are exempt from the fat restriction as they are high in monounsaturated fat, which can help lower LDL "bad" cholesterol and maintain HDL "good" cholesterol. There are not standard portion sizes for snacks but smaller portions are preferred to avoid excess calories from one food item. Best practice would be to include "whole" foods (close to their original state prior to processing, such as: fruits, vegetables, yogurt, cheese and nuts) whenever possible, which contain not only all the original nutrients but also health promoting phytochemicals and other biologically active substances.

Appendix C
Vermont Vending Guidelines

| Grades K-6 | Recommendation | |
|---|---|---|
| | Eliminate the sale of foods outside of the school meal program during the entire school day. Vending may be permitted after school hours and must follow the guidelines for secondary education. | |
| Grades 7-12 | Recommendation | |
| Non-Dairy Beverages | Best Practice | Acceptable Practice |
| | Beverages that contain 100% fruit or vegetable juice. Package size no larger than 8 oz. | Beverages that contain at least 50% fruit or vegetable juice. Package size no larger than 12 oz. |
| Bottled Water | Water without any added ingredients | Water containing fewer than 20 calories per serving without artificial sweeteners |
| Dairy Products | Low fat or nonfat, white or flavored milk, or drinkable yogurt, package size no larger than 10 oz. and total calories fewer than 200 | Low fat or nonfat, white or flavored milk, or drinkable yogurt, package size no larger than 16 oz. and no more than 340 total calories |
| Recommendations for snacks include: | | |
| Cheese | Regular Cheese<br>Serving size should be 1½ oz. or smaller<br>Reduced Fat Cheese<br>Serving size should be 2 oz. or smaller | |
| Yogurt | No larger than 8 oz.<br>8 oz. should be equal to or less than 200 calories per serving<br>6 oz. should be equal to or less than 150 calories per serving<br>4 oz. should be equal to or less than 100 calories per serving | |
| Non-Dairy Snack Foods | Fat:<br>Limit to less than 5 grams of total fat per each 1 oz. serving.<br>(Nuts and seeds are exempt from the fat restriction.) | |
| | Saturated Fat/Trans Fat:<br>Limit to less than 2 grams of saturated or trans fat per each 1 oz. serving. | |
| | Total Carbohydrates:<br>Limit to less than 25 grams of total carbohydrates per each 1 oz. serving. (Fresh, dried or canned fruits are exempt from the carbohydrate restrictions) | |
| | Snack Portion Size:<br>Serving size for snacks should be 2 oz. or less. Smaller portions are preferred. | |
| Vending Sales and Contracts | All foods served and sold should be administered by the school food service.<br>Contracts should include language allowing for purchase of items from another company if not sold by the contracted company. | |

References

*Dietary Guidelines for Americans 2005*

*Regulations of the National School Lunch Program (7 CFR 210) and Regulations of the School Breakfast Program (7CFR 220)*

National Association of State Boards of Education (NASBE)
*Fit, Healthy and Ready To Learn, A School Healthy Policy Guide*

Massachusetts Action for Healthy Kids
*Massachusetts A La Carte Food & Beverage Standards to Promote a Healthier School Environment*

The United States Department of Health and Human Services
*The Surgeon General's Call for Action to Prevent and Decrease Overweight and Obesity, 2001*

Public Health Institute
*California's Obesity Crisis: Focus on Solutions, March 2004*

American Academy of Pediatrics
Policy Statement
*Soft Drinks in Schools*

National Food Service Management Institute (NFSMI)
*Eating at School: A Summary of NFSMI Research on Time Required by Students to Eat Lunch*

United States Department of Agriculture
*Changing the Scene, Improving the School Nutrition Environment*

National Food Service Management Institute
*Relationships of Meal and Recess Schedules to Plate Waste in Elementary Schools*

Montana State University
*MSU News*
"Nutritionists say scheduling recess before lunch is best for students", October 01, 2003

Michigan State University Extension
*Alternatives to Using Food as a Reward*

Durrant K.L. Known and Hidden Sources of Caffeine in Drug, Food and Natural Products.
*Journal of the American Pharmaceutical Association* 42:625-29.

National Association for Sport and Physical Education

North Carolina State Board of Education
*Policy Manual*
"Healthy Active Children – Section 2a"

Arkansas Child Health Advisory Committee
*Recommendations*

*Michigan Policy on Quality Physical Education*

Maine Coordinated School Health Program
*Guidelines*

National Alliance for Nutrition and Activity (NANA)
*Model Local School Wellness Policies on Physical Activity and Nutrition*

# SCHOOL HEALTH SERVICES PRACTICE

## STATEMENT OF PURPOSE:

School health services strengthen and facilitate the educational process by improving and protecting the health status of students and school personnel.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 3 § 165 - Standards of quality for public schools
- 16 V.S.A. Chapter 31 § 1422 - Vision and hearing tests
- 18 V.S.A. Chapter 21 § 1001- Reporting communicable diseases
- 18 V.S.A. Chapter 21 § 1121 - Immunizations required prior to attending school
- 33 V.S.A. Chapter 49 - Child welfare services
- Vermont School Quality Standards, Rules 2120.8.1.3.3
- Vermont State Board of Nursing Position Statement on continuing education for nurses
- Vermont State Board of Nursing Position Statement on Nurses functioning in positions other than for which they are licensed

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Perform vision and hearing screenings as mandated by laws.
2. Evaluate immunization records for meeting school attendance requirements and facilitate the compliance of students with state immunization requirements.
3. Function as a member of the child abuse/neglect reporting team.
4. Report communicable diseases as required.
5. Oversee and practice health services in accordance with state law and school policy and protocols.
6. Administer medication according to the standards of practice (See Medication Section).
7. Maintain up-to-date nursing license, school nurse/associated school nurse licensure from the Department of Education.

## SUGGESTED SCHOOL NURSE ROLES:

1. Act as a case manager for 504 students with health needs.
2. Act as coordinator/chair of the coordinated school health team.
3. Serve as a resource to teachers and administrators in health education and as a member of the health curriculum committee
4. Act as a resource person in promoting health careers.
5. Act as coordinator when collaborating with other school personnel and community members to ensure a safe and healthy school environment and programs for staff and students.
6. Act as coordinator of the child abuse/neglect reporting team.
7. Act as coordinator of the school crisis response team.
8. Coordinate the development of school polices related to health concerns.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Collaborate with administration in development of a clear job description.
2. Provide health services for illness and injuries.
3. Support the development of a safe and healthy school in collaboration with the school community (i.e. OSHA regulations, safe playground, coordinated school health, drugs and alcohol, etc.).
4. Prepare, implement and evaluate individual student health care plans as needed.
5. Provide protocols, training and supervision for delegated health procedures such as ventilators, gastrostomy feedings, tracheotomy care, administration of medication, and catheterization.
6. Educate the school community about chronic and communicable diseases as needed.
7. Act as liaison between school community, local health care providers and local health agencies.
8. Participate on the school crisis response team.
9. Provide guidelines for development of policies and protocols pertaining to health service delivery.
10. Engage in evaluation of health services in collaboration with administration and address needs and methods for making improvements.
11. Collaborate in promotion of staff wellness activities.
12. Pursue professional development opportunities.
13. Participate as a member of school teams to improve student health outcomes.
14. Assess, plan for, implement and evaluate the health needs of students and the school environment.
15. Collect updated emergency and health information on students annually and maintain health records.
16. Provide health education information to students and staff.

## RESOURCES:

- National Association of School Nurses - http://www.nasn.org/
- Safe and Healthy Schools Coordinated School Health Workgroup - http://www.state.vt.us/educ/new/html/pgm_coordhealth.html
- School Liaisons
- Vermont Department of Health - http://www.healthyvermonters.info/
- Vermont State Board of Nursing - http://vtprofessionals.org/opr1/nurses/
- Vermont State School Nurses' Association (VSSNA) - http://www.vssna.org/

## SAMPLE POLICIES, PROCEDURES AND FORMS:

- Guidelines for Establishing Safe School Nurse-to-Student Population Ratios
- Sample Planning Calendar for the Health Services Office
- School Nurse Job Description
- *Role of the School Nurse*. NASN, 2002
- *The Role of the School Nurse in providing School Health Services*. American Academy of Pediatrics, 2001

# Guidelines For Establishing Safe School Nurse to Student Population Ratios

**These guidelines apply to student populations in one building. Students with special needs often require a great deal of the school nurse's time to assess, plan, implement and evaluate their care. Student population numbers listed below need to reflect this by accommodating for the intensity level of the special needs students in a given population. Students who fit into an "*at risk*" category (see definition on following page) need to be counted as 3 students. Students who are moderately physically or emotionally challenged should be counted as 10 students (KSNO, 1994). Students with severe/complicated medical, physical, or mental challenges should be counted as 20.**

| | School Nurse to Student Ratio<br>One Full Time Equivalent / Number of Students<br>( general population - without many special needs students) | | | |
|---|---|---|---|---|
| **Components of School Nursing** | **1 FTE / 350 and below**<br>**Comprehensive School Health Services** | **1 FTE / 500 Students**<br>**Core School Health Services** | **1 FTE / 750 Students**<br>**Minimum School Health Services** | **1 FTE / 800 and above**<br>**Inadequate School Health Services** |
| 1. First Aid & Emergency Care | Yes | Yes | Yes | Yes |
| 2. Child Abuse & Neglect | Yes | Yes | Yes - follow up limited | Limited |
| 3. Communicable Disease Control | Yes | Yes | Limited | Very Limited |
| 4. Health Screening | Yes - with follow up | Yes - follow up limited | Limited | Very Limited |
| 5. Health Counseling | Yes | Yes | Limited | Very Limited |
| 6. Health Appraisal | Yes | Yes | Limited | **Very Limited to None** |
| 7. Medication Administration | Yes | Yes | Yes | Yes |
| 8. Consultation, Planning and Implementation of Care for Special Needs Students | Yes | Limited | Very Limited | **Very Limited to None** |
| 9. Substance Abuse Intervention | Yes | Yes | Limited | Very Limited |
| 10. Health Education Resource/Provider | Yes - Provider – classroom participation possible | Yes - Resource - limited classroom participation | Limited – Resource only | Very Limited |
| 11. School Personnel Health Services | Yes | Limited | Very Limited | **Very Limited to None** |
| 12. Safety School Environment | Yes | Limited | Very Limited | **Very Limited to None** |

**Additional factors to consider when establishing safe school nurse to student population ratios are:**

1. *The number of buildings the nurse covers* - The travel time and the fact that the nurse is not always present to carry out such things as first aid and medication administration limits the coverage that she/he can provide. Ratios need to be lower in these situations. For example, the minimum school health services ratio of 1/750 needs to be lowered to 1/500 students in a maximum of five buildings, each of which is accessible within thirty minutes (Vermont Standards of Practices: School Health Services, 1995).

2. *The staffing patterns - the use of unlicensed and licensed personnel* such as secretaries and licensed practical nurses to cover the health office in the nurse's absence or to augment health services. The delegation of nursing tasks to these persons requires training and monitoring by the school nurse. Adequate time must be available for these functions.

3. *The amount of time and responsibility the nurse takes for health education.* Coordination, planning and lesson preparation can require large amounts of time away from other school nursing tasks. The more the nurse is involved with health education the lower the ratios must be to allow for proper follow through in the area of health services.

**"At risk" students may be characterized by any one or more of the following indicators**:

1. A high rate of absenteeism from school - ten days or more;
2. Failure to achieve grade level standards;
3. Failure in two or more subjects or courses of study;
4. Behind in credits to graduate;
5. Retention at grade level one or more times;
6. Below grade level for students of the same age;
7. Pregnancy or parenthood or both;
8. Repeated commission of disciplinary infraction;
9. Member of a house hold that is at or below the poverty level using criteria for free and reduced lunch program;
10. Limited English proficiency;
11. Identified victim of physical, sexual, or emotional abuse and/or neglect;
12. Health or substance abuse problems;
13. Attempted suicide;
14. Identified as medically fragile or has special health needs;
15. Identified with an I.E.P. for Special Education, as 504, as gifted or with speech problems.

(KNSO,1994)

**Adopted 1/14/98 by The School Nurse Advisory Board to the Vermont Department of Education and the Vermont State School Nurse's Association**
**Adopted 12/16/98 by Vermont's Legislative Committee on Administrative Rules as part of the School Quality Standards**
**Adopted 1/99 by the Vermont Legislature**

# Guidelines For Establishing Safe School Nurse to Student Population Ratios

## BIBLIOGRAPHY

American Nurses Association. (1983). *Standards of School Nursing Practice*. (pp. 18-19). Kansas City, MO: American Nurses Publishing.

Burt,C., Beetem, N., Iverson, C., Hertel, V., Ambler Peters, D. (1996). Preliminary Development of the School Health Intensity Rating Scale. *Journal of School Health,* 66(8), 286-290.

Fryer, G., Igoe, J., (1995). A Relationship Between Availability of School Nurses and Child Well-being. *Journal of School Nursing. 11(3), 12-18.*

Kansas School Nurse Organization (KSNO). (1994*). Assigning School Nurse Services According to Student Population Acuity*. (pp. 2). Kansas School Nurses Publishing.

School Nurse's Advisory Board to Vermont Department of Education. (Updated each year). *Standards of Practice: School Health Services Manual*. Montpelier, VT: Vermont Department of Education.

# SAMPLE PLANNING CALENDAR FOR THE HEALTH SERVICES OFFICE

## AUGUST

- SEND MEDICATION REMINDER NOTICES - requesting signed medication forms prior to first day of school.

- CALL PARENTS of children with health needs, IHP, medications as needed.

- BEGINNING OF YEAR LETTERS:
  - ☐ Welcome
  - ☐ Annual Questionnaire

- IMMUNIZATIONS/BIRTH CERTIFICATES:
  - ☐ List of students not yet in compliance

- UPDATE LISTS/STUDENT RECORDS:
  - ☐ Alphabetical list (whole school)
  - ☐ Class lists
  - ☐ Physical/dental insurance class lists

- LIST OF AREA DOCTORS AND DENTISTS for reference during the year.

- STAFF HANDOUTS:
  - ☐ Emergency information cards
  - ☐ Health room passes
  - ☐ First aid baggies (gloves, band aids, tooth chests)

- DEVELOP AND SEND NUT LETTERS TO CLASSROOMS

- MAKE NUT/SAFE ALLERGY AWARE SIGNS for Lunchroom tables
  - ☐ Classroom doors

- PTO SIGN-UP FOR HEALTH SCREENING

## SEPTEMBER

- REVIEW RECORDS/GATHER DATA REGARDING Students with asthma and/or other allergies
  - ☐ Students with epi-pens
  - ☐ Students without health insurance
  - ☐ Forbidden Access / Court Orders
  - ☐ Students without medical/dental homes
  - ☐ Special services requested

- MEET WITH INDIVIDUAL FACULTY/STAFF REGARDING HEALTH NEEDS OF STUDENTS, on a need to know basis [This can be completed in August as well].

- DEVELOP INDIVIDUAL HEALTH CARE PLANS/EMERGENCY PROTOCOLS for students with special health care needs:
  - ☐ Take photo of kids for protocols, master list, and food personnel.
  - ☐ Have protocol signed by parent, teacher, principal, and nurse.
  - ☐ Make field trip mini protocols and copy emergency cards for field trips.

- INSERVICE TRAINING for health office staff or delegates who will perform health services, including medication administration, health office protocols. [This can be completed in August as well].

Train teachers, support staff and paraprofessionals for allergy reaction symptoms, epi pen use, seizures and asthma symptoms. Include as appropriate:
- ☐ Recess/lunchroom staff
- ☐ Food service personnel
- ☐ Bus drivers
- ☐ Specials teachers
- ☐ Office staff

- IMMUNIZATIONS, BIRTH CERTIFICATES & OTHER BEGINNING OF THE YEAR PAPERWORK: Check for completeness on each child
  - ☐ Send reminder notice during first week of school
  - ☐ Notify principal of any student not in compliance with immunizations

- SEND HOME ASTHMA UPDATE FORM

- COLLECT MEDICATIONS/MD ORDERS/PARENT SIGNED MEDICATION FORMS

- SCHEDULE SCREENING for Vision, Hearing, as indicated in the standards of practice.
  - ☐ Schedule rooms for screening
  - ☐ Class lists
  - ☐ Solidify volunteers
  - ☐ Email/letter to teachers indicating schedule

- SCHEDULE 504 MEETINGS

- BLOOD BORNE PATHOGENS TRAINING FOR STAFF

- INPUT HEALTH ALERTS into School Master.

- INPUT IMMUNIZATIONS into School Master.

- UPDATE SUB NOTEBOOK.

**OCTOBER**

- SCREENING:
  - ☐ Begin/continue to screen.
  - ☐ Enter screening data on charts
  - ☐ Referrals to parents - written and/or verbal

- IMMUNIZATION FOLLOW-UP

☐ Contact families of students not in compliance, give immunization clinic data, medical home information, etc (Form #2, notice p.18, immunization law)
☐ Review list of immunization reports
☐ Give families November deadline for immunization information, MD appt, exclusion, etc. as appropriate

**NOVEMBER**

- IMMUNIZATIONS:
  - ☐ Send letter from principal the first week of November
  - ☐ Deadline for receiving immunization information is one week before Thanksgiving.

- PREPARE VERMONT DEPT. OF HEALTH IMMUNIZATION REPORT (due on December 1st)

**DECEMBER**

- IMMUNIZATIONS
  - ☐ Notify principal of any student not in compliance
  - ☐ Send exclusion letter to family signed by principal and SN (Notice p. 19, immunization law)
  - ☐ Exclusion for non-compliance to start January 1st
  - ☐ Notify Superintendent of students excluded for non-compliance

* DOCUMENT ALL CONTACT WITH FAMILIES REGARDING IMMUNIZATIONS IN SCHOOL MASTER**

**JANUARY**

- Vision and Hearing completed and follow-up from referrals

- SEND REMINDER NOTICES TO PARENTS

**MAY**

- FINISH SCREENING REPORT TO THE DEPT. OF EDUCATION: blood pressure, hearing, vision, etc. Submit by June 1st.

- Have all immunizations in School Master, including incoming Kindergarten.

- INPUT INCOMING K HEALTH INFORMATION - on lists and health alerts in School Master

**JUNE**

- SUPPLY INVENTORY/ORDER SUPPLIES

- WRITE BEGINNING OF SCHOOL LETTERS

- FILE MEDICATION SHEETS, ACCIDENT REPORTS, LOG BOOK
- ENTER STATISTICAL DATA FOR THE YEAR AND PRINT
- PRINT IMMUNIZATIONS ON CHILDREN WHO ARE MOVING

**CONTINUOUS THROUGHOUT THE YEAR:**

Keep records up to date, daily log book up to date, School Master input of immunizations and daily log. Fill out accident reports as necessary, head lice control, data collection for final reports. Health room maintenance, attendance at staff meetings and parent, teacher meetings. Teacher follow-up, monthly bulletin boards, monthly newsletters, community liaison work and student/parent communication.

**Sample Job Description**

**Title:** School Nurse or Associate School Nurse

**Job Responsibilities**: The school nurse strengthens and facilitates the educational process by modifying or removing health related barriers to learning for individual students and by promoting an optimal level of wellness for students and staff. The nurse assumes responsibility and accountability for the assessment of the health needs of a student, a plan of action, implementation, and evaluation of the plan. The school nurse is also responsible for the delegation of nursing tasks to a designated person(s) in the school setting. This practice is done in accordance with the accepted standards of nursing as defined by the profession. The school nurse will serve as the direct link between physicians, families and community agencies to assure access and continuity of health care for the students. The school nurse will provide care, relevant instruction, counseling, and guidance to students. The school nurse practices in accordance with the current standards and functions as defined by the Vermont Practice Act and the Standards of Practice: School Health Services.

**Time**: The school nurse will work in accordance with the number of days established annually by the school board in the school calendar.

**Requirements**:

**School Nurse:**

1. Has earned a baccalaureate or master's degree from an accredited nursing program.
2. Has a current valid license to practice professional nursing issued by the Vermont Board of Nursing.
3. Has four years of clinical nursing experience beyond nursing education.
4. Holds a valid education license with an endorsement as a school nurse.
5. Holds a current certificate in cardiopulmonary resuscitation (CPR) and first aid.
6. Has completed an educational orientation program provided through the Department of Education and based on the requirements for delivery of health services as defined in the *Vermont School Quality Standards* and the Vermont manual *Standards of Practice: School Health Services.*
7. Has successfully completed the Praxis I exam or met developed criteria from Graduate Record Exam, Scholastic Aptitude Test or the American College Test as outlined by the Department of Education.
8. Will renew Registered Nurse license every two years.
9. Will renew School Nurse License every seven years in collaboration with the local school district Standards Board.
10. Will hold a dual certification in Health Education if contracted to provide a daily health education assignment.

**Associate School Nurse:**

1. Has earned an Associate's Degree/Diploma from an accredited nursing program.
2. Has a valid license as a Registered Nurse (RN) in the state of Vermont.
3. Has four years of clinical nursing experience that includes community health and pediatric nursing.
4. Holds a current certificate in cardiopulmonary resuscitation (CPR) and first aid.
5. Has completed an approved educational orientation program provided through the Department of Education and based on the requirements for delivery of health services

as defined in the Vermont *School Quality Standards* and the Vermont manual titled *Standards of Practice: School Health Services.*

6. Has successfully completed the Praxis I exam or met developed criteria from Graduate Record Exam, Scholastic Aptitude Test or the American College Test as outlined by the Department of Education
7. Will renew Registered Nurse license every two years
8. Will renew Associate School Nurse license every seven years with the local school district Standard's Board

**Work Performed**:

**Provider of Student Health Care**

1. Provides *mandated screening programs.
2. Completes Immunization audit and reports
3. Determines Student Access to Medical and Dental Providers
4. Determines health care needs of the students within the school and develops a health are plan.
5. Interprets the health and developmental assessments to parents, teachers, administrators, and other appropriate professionals.
6. Provides communicable disease control procedures and advises administration and parents regarding school exclusion and re-admittance, and may arrange transportation when appropriate.
7. Provides appropriate assessment and care for the students with special health care needs.

**Planner and Coordinator of Student Health Care**

1. Complies and maintains appropriate statistical information:

| **School:** | **State**: |
|---|---|
| Immunization | Immunization audits |
| Student Health Records | Hearing and vision data |
| Daily log | |
| Medication log | |
| Accident report | |
| Annual report | |

2. Provide and document training of delegated procedures
3. Assists in formulating health policies
4. Participates with administration in the process of evaluation and goal setting.
5. Maintains professional competencies through in service educational activities and/or self selected professional growth activities.
6. Promoter of a healthful school environment. Monitors, reports and recommends changes for safety hazards and sanitary conditions in the school environment.

**Resources for staff and community**

1. Use health services as a means of health teaching.
2. Provide in service training for health related issues as indicated.
3. Serve as a faculty member in the total school program
4. Provide staff and parents information and counseling concerning individual students' health problems, including the participation in staffing as needed.
5. Provide staff and parents with information on current health practices and problems,

including identifying and dealing with health problems, locating resources and maintenance of information displays, bulletin boards, etc.

6. Participate on teams

**Health Educator**

1. Act as a resource person and consultant for health education in the classroom setting.

**Other**

**Evaluation and Supervision**: School Nurse receives supervision and evaluations from building or district administrators using the same schedule and process as other teaching staff. The school nurse should be evaluated on both school nurse practice as determined by his/her job description and personal development plan.

National Association of School Nurses

**ISSUE BRIEF**

***School Health Nursing Services Role in Health Care***

**Role of the School Nurse**

## INTRODUCTION

The practice of school nursing began in the United States on October 1, 1902 when the initial role of the school nurse was to reduce absenteeism by intervening with students and families regarding health care needs related to communicable diseases. While the nurse's role has expanded greatly from its original focus, the essence of the practice remains the same. The school nurse supports student success by providing health care assessment, intervention, and follow-up for all children within the school setting.

## BACKGROUND

In 1999, the National Association of School Nurses Board of Directors defined school nursing as:

> A specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning.

Inherent in this definition is the framework that school nurses engage in professional nursing practice, use the nursing process for decision-making, document the care they provide, and assure confidentiality. Professional nurses address the physical, mental, emotional, and social health of their clients. In addition, professional school nurses have as the ultimate outcome of their practice, the support of student success in the learning process. In this context the school nurse provides services to the entire school population, which may include infants, toddlers, pre-schoolers, children with special needs, traditional school populations, and, to a limited degree, adults within the school community.

## ROLE OF THE SCHOOL NURSE

Seven roles of the school nurse have evolved from this definition.

**The school nurse provides direct health care to students and staff.**
The school nurse provides care to students and staff who have been injured or who present with acute illnesses. Care may involve treatment of health problems within the scope of nursing practice, communication with parents for treatment, and referral to other providers. The school nurse uses the nursing process to assess, plan, implement, and evaluate care for students with chronic health conditions. This care should begin with the development of a nursing care plan (also known as an individualized health care plan) that should include an emergency action plan. The school nurse is responsible for medication administration and the performance of health care procedures that are within the scope of nursing practice and are ordered by an appropriately licensed health care provider. The school nurse also assists faculty and staff in monitoring chronic health conditions. As the scope of nursing practice expands to utilize the increasingly complex technology needed to provide up-to-date care for clients, the school nurse's body of knowledge grows through personal professional development.

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**The school nurse provides leadership for the provision of health services.**
In addition to providing health services directly, the school nurse must take into account the nature of the school environment, including available resources. As the health care expert within the school, the school nurse assesses the overall system of care and develops a plan for assuring that health needs are met. This leadership role includes developing a plan for responding to emergencies and disasters and training staff to respond appropriately. It also involves the appropriate delegation of care within applicable laws. Delegation to others involves initial assessment, training, competency validation, supervision, and evaluation by the school nurse.

**The school nurse provides screening and referral for health conditions.**
In order to address potential health problems that are barriers to learning or symptoms of underlying medical conditions, the school nurse often engages in screening activities. Screening activities may include vision, hearing, postural, body mass index, or other screening. Determination of which screenings should be performed is based on several factors, including legal obligations, the validity of the screening test, the cost-effectiveness of the screening program, and the availability of resources to assure referral and follow-up.

**The school nurse promotes a healthy school environment.**
The school nurse provides for the physical and emotional safety of the school community. The school nurse monitors immunizations, assures appropriate exclusion from and re-entry into school, and reports communicable diseases as required by law. The school nurse provides leadership to the school in implementing precautions for blood borne pathogens and other infectious diseases. The school nurse also assesses the physical environment of the school and takes actions to improve health and safety.
Such activities may include an assessment of the playground, indoor air quality evaluation, or a review of patterns of illness or injury to determine a source of concern. Additionally, the school nurse addresses the emotional environment of the school to decrease conditions that may lead to bullying and violence and/or an environment not conducive to optimal mental health and learning.

**The school nurse promotes health.**
The school nurse provides health education by providing health information directly to individual students, groups of students, or classes or by providing guidance about the health education curriculum, encouraging comprehensive, sequential, and age appropriate information. They may also provide programs to staff, families, and the community on health topics. Other health promotion activities may include health fairs for students, families, or staff, consultation with other school staff such as food service personnel or physical education teachers regarding healthy lifestyles, and staff wellness programs. The school nurse is a member of the coordinated school health team that promotes the health and well-being of school members through collaborative efforts.

**The school nurse serves in a leadership role for health policies and programs.**
As the health care expert within the school system, the school nurse takes a leadership role in the development and evaluation of school health policies. The school nurse participates in and provides leadership to coordinated school health programs, crises/disaster management teams, and school health advisory councils. The school nurse promotes nursing as a career by discussions with students as appropriate, role modeling, and serving as a preceptor for student nurses or as a mentor for others beginning school nursing practice. Additionally, the school nurse participates in measuring outcomes or research, as appropriate, to advance the profession and advocates for programs and policies that positively affect the health of students or impact the profession of school nursing.

**The school nurse serves as a liaison between school personnel, family, community, and health care providers.**
The school nurse participates as the health expert on Individualized Education Plan and 504 teams and on student and family assistance teams. As case manager, the nurse communicates with the family through telephone calls, assures them with written communication and home visits as needed, and serves as a representative of the school community. The school nurse also communicates with community health providers and community health care agencies while ensuring appropriate confidentiality, develops community partnerships, and serves on community coalitions to promote the health of the community.

The school nurse may take on additional roles to meet the needs of the school community.

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## CONCLUSION

Healthy children are successful learners. The school nurse has a multi-faceted role within the school setting, one that supports the physical, mental, emotional, and social health of students and their success in the learning process.

## REFERENCES

Harrigan, J. F. (2002). *Overview of school health services*. Scarborough, ME: National Association of School Nurses.

National Association of School Nurses (1999). *Definition of school nursing*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Issue brief. Case management of children with special healthcare needs*. Castle Rock: CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Issue brief. Integrated service delivery*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2000). *Issue brief. Mental health and illness*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Issue brief. School nurses and the individuals with disabilities act*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2000). *Issue brief. School Violence*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Issue brief. Screening for vision impairment*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Issue brief. Section 504 of the rehabilitation act of 1973*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Position statement. Coordinated school health program*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. Delegation of care*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (1998). *Position statement. Emergency care plans for students with special health care needs*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (1998). *Position statement. Government relations : public policy, legislative, and regulatory participation*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (1998). *Position statement. Healthy school environment*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Position statement. Immunizations*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (1998). *Position statement. Individualized health care plans*. Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2000). *Position statement. Indoor air quality*. Castle Rock, CO: Author. Available at www.nasn.org

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National Association of School Nurses (2001). *Position statement. Infectious diseases.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (1997). *Position statement. Medication administration in the school setting.* Castle Rock: CO, Author. Available at www.nasn.org

National Association of School Nurses (2000). *Position statement. Mental health of students.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. Overweight children and adolescents.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. Regulations on blood borne pathogens in the school setting.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. Reproductive health education.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Position statement. Role of the school nurse in services to preschool children co–located on school campuses during school hours.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (1996). *Position statement. The school nurse and specialized health care services.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. School nurse role in bio terrorism emergency preparedness.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Position statement. School nurse role in care and management of the child with diabetes in the school setting.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Position statement. School nurse role in emergency preparedness.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. Soft drinks and candy in the school setting.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2002). *Position statement. Using assistive personnel in school health services programs.* Castle Rock, CO: Author. Available at www.nasn.org

National Association of School Nurses (2001). *Scope and Standards of Professional School Nursing Practice.* Scarborough, ME: Author.

2002

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AMERICAN ACADEMY OF PEDIATRICS

Committee on School Health

# The Role of the School Nurse in Providing School Health Services

**ABSTRACT. The school nurse has a crucial role in the provision of school health services. This statement describes the school nurse as a member of the school health services team and its relation to children with special health care needs. Recommendations for the professional preparation and education of school nurses also are provided.**

ABBREVIATION. AAP, American Academy of Pediatrics.

## SCHOOL NURSE ACTIVITIES

Changes in society, the provision of health care, education, and the family have increased the need and demand for school health services. New paradigms are evolving for school health services as school systems develop comprehensive school health programs to address the diverse and complex health problems of today's students.[1] In addition to health issues, schools must cope with problems caused by immigration, homelessness, divorce, remarriage, poverty, substance abuse, and violence.[2]

The school nurse has a central management role in the implementation of the school health services program for all children and youth in the school. Ideally, the school nurse collaborates with primary care physicians, specialists, and local public health and social service agencies to ensure a full spectrum of effective and quality services that sustain children, youth, and their families. All school health services are delivered in the overall context of the child, the family, and the child's overall health plan.

The goals of a school health program that relate directly to the health service component as outlined in the American Academy of Pediatrics (AAP) manual *School Health: Policy and Practice*[3] are to:

- ensure access to primary health care (a medical home);
- provide a system for dealing with crisis medical situations;
- provide mandated screening and immunization monitoring; and
- provide a process for identification and resolution of students' health care needs that affect educational achievement.

These goals are a major component of the larger school health program and focus on prevention and early intervention. The school nurse has a critical role within this school health program and provides acute, chronic, episodic, and emergency health care. In addition, the school nurse provides health education and health counseling and advocates for students with disabilities. School nurses are well positioned to take the lead for the school system in partnering with community physicians, community organizations, and Medicaid and State Children's Health Insurance Program staff to assist families and students to enroll in the state health insurance programs and find a medical home for each student.

## SCHOOL HEALTH SERVICES TEAM

The school nurse functions as a member and often the coordinator of the school health services team. The team may include a school physician, licensed practical nurses, health aides and clerical staff, school counselors, school psychologists, school social workers, and substance abuse counselors. A pediatrician often fills the school physician role because he or she is knowledgeable about general pediatrics, school health, and adolescent health. In some schools, a pediatric family nurse practitioner functions as the school nurse and may provide additional services. If unlicensed assistive personnel are part of the school health services team, their performance of skilled nursing procedures must be supervised by the school nurse in accordance with state laws.

Some schools may have a school-based health center in or adjacent to the school, which may provide primary care and psychosocial services. The school nurse coordinates the activities of the school health services team with the child's primary care physician and/or with the school-based health center to provide continuity of care and prevent duplication of services.

## THE SCHOOL NURSE AND CHILDREN WITH SPECIAL HEALTH NEEDS

The school nurse has a unique role in the provision of school health services for children with special health needs, including children with chronic illnesses and disabilities of various degrees of severity. These children are included in the regular school classroom setting as authorized by federal and state laws. As a leader of the school health team, the school nurse must assess the student's health status, identify health problems that may create a barrier to educational progress, and develop a health care plan for management of the problems in the school setting. The school nurse ensures that the student's

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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individual health care plan is part of the individual education plan or other written plan[4] and that both plans are developed and implemented with full team participation, with parents and the child enlisted as partners. The school nurse's participation in the educational plan development heightens the potential for achieving the goals of the health care plan, which are to maximize the student's educational experience and to provide adequate preparation for responses to urgent situations. The school nurse develops this plan with the student, parents or guardians, and the child's primary care physician. Dialogue with subspecialists, community agency staff, and case managers can add important information. The school nurse must provide safe and effective direct services or facilitate the performance of special health care procedures, such as tracheostomy suctioning, bladder catheterization, ostomy care, nasogastric feedings, maintenance of orthopedic devices, and ventilator care, for all students who need them.

The school nurse should collect important information, such as special needs, modifications to routine medical procedures, allowance to administer stock over-the-counter medications in school (if offered), medical home, health insurance, emergency measures, and parent permission, to interact with the student's health care providers. The Emergency Information Form from the AAP and American College of Emergency Physicians, for example, could be used as a template for formulation of the individual medical plan.[5]

## PROFESSIONAL PREPARATION FOR SCHOOL NURSES

The AAP supports the goal of professional preparation for all school nurses. The National Association of School Nurses has determined that the minimum qualifications for the professional school nurse should include licensure as a registered nurse and a baccalaureate degree from an accredited college or university.[6] In addition, there should be a process by which certification or licensure for the school nurse is established by the appropriate state board. The AAP recommends the use of appropriately educated and selected school nurses to facilitate and provide school health services. In its *Healthy People 2010* objectives,[7] the US Department of Health and Human Services recommends at least 1 nurse per 750 students, with variation depending on the community and the student population.

## CONCLUSION

The AAP recommends and supports the continued strong partnership among school nurses, other school health personnel, and pediatricians. These partners should work together closely to promote the health of children and youth by facilitating the development of a comprehensive school health program, ensuring a medical home for each child,[8] and integrating health, education, and social services for children at the community level.



## REFERENCES

1. Small ML, Majer LS, Allensworth DD, Farquhar BK, Kann L, Pateman BC. School health services. *J Sch Health*. 1995;65:319–326
2. Passarelli C. School nursing: trends for the future. *J Sch Nurs*. 1994;10:10–20
3. American Academy of Pediatrics, Committee on School Health. *School Health: Policy and Practice*. Elk Grove Village, IL: American Academy of Pediatrics; 1993:9–16
4. Nondiscrimination on the basis of handicap in programs receiving or benefiting from federal financial assistance. 34 CFR 104, Subpart D—Preschool, elementary, and secondary education (2000)
5. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Emergency preparedness for children with special health care needs. *Pediatrics*. 1999;104(4). Available at: http://www.pediatrics.org/cgi/content/full/104/e53
6. National Association of School Nurses. *Position Statement: The Professional School Nurse Roles and Responsibilities: Education, Certification, and Licensure*. Scarborough, ME: National Association of School Nurses; 1996
7. US Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health Objectives for Improving Health*. 2nd ed, 2 volumes. Washington, DC: US Government Printing Office; 2000
8. American Academy of Pediatrics, Ad Hoc Task Force on Definition of the Medical Home. The medical home. *Pediatrics*. 1992;90:774

# SCREENING

## STATEMENT OF PURPOSE

Student health issues that may be barriers to learning will be identified and addressed by collaboration between the school nurse, the family and the medical home.

## AUTHORIZATION - LEGAL REFERENCES

- 16 V.S.A. Chapter 31 § 1422 – Vision and hearing tests
- 16 V.S.A. Chapter 101 § 2942 – Special education definitions
- Vermont School Quality Standards - Section 2120.8.1.3.3
- Vermont Department of Education and Vermont Department of Health Memorandum on Collecting Student Height and Weight Information in School, December 9, 2004

## DEFINITION

**Screening** – The examination of a group of usually asymptomatic individuals to detect those who have a probability of developing a given disease or health problem.

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Obtain knowledge of the requirements and recommendations for scheduled screening exams. **(**See *Required and Recommended Screening Chart* )
2. Decide which screening exams will be done at the specified grade levels – at the least, all health screening exams required by law must be completed each year. Assist in Early Essential Education screening as you are able. All initial screening should be done within the first three months of school. If a student fails the initial exam, a second screening is done with referral to the medical home, if necessary. This should be completed by December 31.
3. Find a screening site fitting the need of the specific screening exams and large enough to provide appropriate space and privacy for the screener and students being screened.
4. Obtain and maintain appropriate screening equipment and calibrate yearly. (See *Resources* - Equipment Calibration)
5. Evaluate the results of the screening exams and send referrals to parents of students failing the screening, recommending further evaluation at the medical home. (See *Sample Protocols and Forms* referral letter)
    a. Include information on the Dr. Dynasaur Program, a space for the health care provider's examination findings and recommendations and instruction to return the form to the school nurse/associate school nurse.
    b. Contact parents if the screening results form is not returned within a month.
    c. Report results of the screening exam to appropriate school personnel with recommendations for accommodations.
    d. Screening results can be sent directly to the medical provider with permission from the parent/guardian.
6. Notify in writing parents/guardians of a student who is unable to perform the screening exams and include a recommendation for a professional examination.

7. Record all screening results in the student's permanent health record including notations of referral, referral results and/or follow-up.
8. Report all screening statistics to administration and results of vision and hearing screening to the Department of Education in Annual Health Services Screening Report.

## SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES

### VISION

1. Carry out vision and hearing exams on students who:
   - repeated a grade
   - receive special education
   - have any chronic medical condition conducive to vision and hearing difficulties
   - have signs and/or symptoms of vision or hearing difficulties
   - wears corrective lens(es)/hearing aids or use hearing amplification equipment
   - were referred to the educational support team
   - failed the screening exam last year
   - were referred by staff or parents
   - are new to the school and not screened in the last six months
   - are entering the Early Essential Education Program

2. Consider screening students who report or are observed with:
   - strabismus
   - inflamed, edematous and/or encrusted eyelid(s)
   - inflamed and/or tearing eye(s)
   - recurring styes
   - complaints of double or blurred vision
   - complaints of dizziness, headaches, or nausea, following close work
   - inability to see well at near or far distance
   - holding book too close
   - squinting, frowning, blinking or rubbing eyes excessively
   - straining to see (shutting one eye, tilting head, thrusting head forward)
   - drooping eyelid(s)
   - stumbling over small objects

3. Carry out a comprehensive vision screening program that screens for:
   - distance visual acuity
   - near visual acuity starting in second grade
   - ocular alignment (muscle balance/phoria)
   - color discrimination in K or 1st grade in males only

4. Train students unfamiliar with the vision screening process and equipment. The Snellen Letter Chart is the preferred screening tool for visual acuity. Testing distance of ten feet is recommended for distance acuity charts that are designed for ten feet. If the child cannot perform this test, the following tests are available for use:
   - Allen Picture Card test
   - HOTV set for lighted Insta-Line Vision Tester
   - Faye Symbol Chart
   - Michigan Preschool slides for Titmus
   - Blackbird Vision Screening System
   - Lea Symbols

   **You can purchase these testing materials from most school nursing catalogs**.

5. Evaluate the vision screening results and refer to medical home as appropriate.

## HEARING

1. If possible, receive training for hearing screening by an audiologist.
2. Use a quiet screening room free of distractions and noises.
3. Use equipment acceptable for comprehensive hearing exam such as a pure tone audiometer. Audiometers need calibration evaluations at least yearly or semiannually if greater than five years old or subject to rough handling. Appropriate handling and care of audiometric equipment is essential:
   - avoid extreme temperature
   - in transporting, place flat on the seat of automobile
   - avoid rough handling
4. When possible use pure tone screening as the preferred method for screening hearing. It includes:
   - hand raising or pressing button response to hearing the various tones generated by the audiometer (more valid with older students)
   - play audiometry response technique. A young child can be taught to respond to pure tone sounds but consistency in the teaching method is essential. (See Procedure for Pre-school Puretone Screening and Play Conditioned Audiometry)
5. Train students unfamiliar with the screening process and equipment.
6. Carry out a comprehensive hearing screening program that screens for hearing levels at frequencies of 500, 1000, 2000, and 4000 Hz using 20db if a sound proof room is available or 25db if a sound proof room is not available.
7. Evaluate the hearing exam results and refer to medical home as appropriate.

## HEIGHT AND WEIGHT (OPTIONAL SCREENING)

1. Obtain the necessary calibrated equipment for a comprehensive heights and weights measuring program such as:
   - scale(s)
   - height measuring device
   - height and weight charts for boys and girls.
2. Assure privacy and accurate height and weight measurements of the student by having the student remove heavy clothing and shoes.
3. Evaluate height and weight data obtained using growth charts to plot Body Mass Index (BMI) for age and refer as appropriate to medical home.
4. Aggregate height and weight data using the format provided by the Department of Education on an annual basis.

## BLOOD PRESSURE (OPTIONAL SCREENING)

1. Consider screening students in the recommended grades and who report or are observed with:
   - known normally elevated or high blood pressure
   - headaches or dizziness
   - fatigue
   - shortness of breath
   - edema
   - obesity
   - visual disturbances
   - chest pain.

2. Evaluate blood pressure readings utilizing the VDH Health Screening for Children & Adolescents Provider's Toolkit.
3. Re-screen when systolic pressure, diastolic pressure or both are at the 90th percentile or above for the student's age and gender. Obtain three readings at least one day apart but not more than one week apart.
4. Refer to medical home as appropriate.

## RESOURCES

- American Academy of Ophthalmology - www.aao.org
- *Blood Pressure Levels for the 90th and 95th Percentiles for Boys and Girls Ages 1-17 years by Percentiles of Height*
- National Association of School Nurses – www.nasn.org - Pamphlets can be purchased at a low cost on the various screening exams.
- Required and Recommended Screenings
- Screening Program Flow Chart
- State of Vermont Division for the Blind and Visually Impaired http://www.dad.state.vt.us/dbv
- Vermont Association for the Blind and Visually Impaired - http://www.vabvi.org
- Vermont Department of Health - Division of Health Improvement: Children with Special Health Needs – Hearing Health and Communications Program
- Equipment Calibration:

  Antec Calibration - Toni Summers
  P.O. Box 8264
  Brattleboro, VT 05304
  (603) 256-6677 (Fax 256-6180)

  Technical Services Program - Tim Agan
  University of Vermont
  (802) 656-3255 Ext. 0078
  Timothy.Agan@uvm.edu
- Center for Disease Control and Prevention – www.cdc.gov – for growth charts – www.cdc.gov/growth charts
- Commissioner's Letter on collecting Body Mass Index (2004)
- National Association of School Nurses – www.nasn.org - Pamphlets can be purchased at a low cost on the various screening exams.
- Tools for Calculating Body Mass Index (BMI) - http://www.cdc.gov/nccdphp/dnpa/growthcharts/bmi_tools.htm
- Vermont Department of Health – Health Screening for Children and Adolescents:
- Provider Tool Kit Burlington, VT.

## SAMPLE POLICIES, PROCEDURES AND FORMS

- Screening Program Flow Chart
- Required and Optional Screenings
- Screening Forms
  a. Mass screening – Hearing
  b. Mass screening – Vision
- Vision Referral Letters
- Glossary of terms from NASN's booklet, *Vision Screening Guidelines for School Nurses*
- Hearing Information
  a. Audiogram of Familiar Sounds from the Luce Center
  b. Procedure of Pre-school Puretone Screening and Play Conditioned Audiometry

c. Relationship of Degree of Long-term Hearing Loss to Psychosocial Impact
d. Helping the Hard of Hearing (Students with Special Needs)

- Hearing and Vision Screening of Students with Disabilities, Vermont Department of Education Memorandum, January 22, 2003

## VISION CRITERIA FOR REFERRAL

1. Pre K - 12 distant and near visual acuity:
   a. Passing results are seeing at least 20/30 in both eyes.
   b. Failing results are seeing at 20/40 level or above in either eye.

2. A two-line difference in visual acuity between the right and left eyes.

3. Failure of ocular balance (muscle balance) at **both** near **and** far, - if this problem has not been identified and referred before.

4. An obvious mal-alignment or wandering eye.

5. If a student has had follow-up for vision loss, but more than three months have elapsed with the loss still apparent, it is recommended by the American Academy of Pediatrics that a student be re-evaluated.

6. If a student is unable to be screened.

7. Referrals can also be made for observations such as:
   - Injected conjunctiva with abundant purulent drainage
   - Inflamed, edematous, and/or encrusted eyelid(s)
   - Reaction to screening i.e., squinting, frowning, scowling, puckering of face, or refusal to have one eye covered
   - Watering, itching, pain, blurring or double vision
   - Thrusting head forward or tilting head
   - Closing one or both eyes during test
   - Deviation of eyes
   - Photophobia
   - Poorly fitting or scratched corrective lens(es)

## HEARING CRITERIA FOR REFERRAL

1. Passing results are:
   - hearing at 20 dB in sound proof room; or
   - hearing at 25 dB in a non-sound proof room.

2. Failing results are: initial and rescreening at 30 dB or greater for one frequency in either ear.

3. If a student is unable to be screened.

## CRITERIA FOR REFERRAL - HEIGHT AND WEIGHT

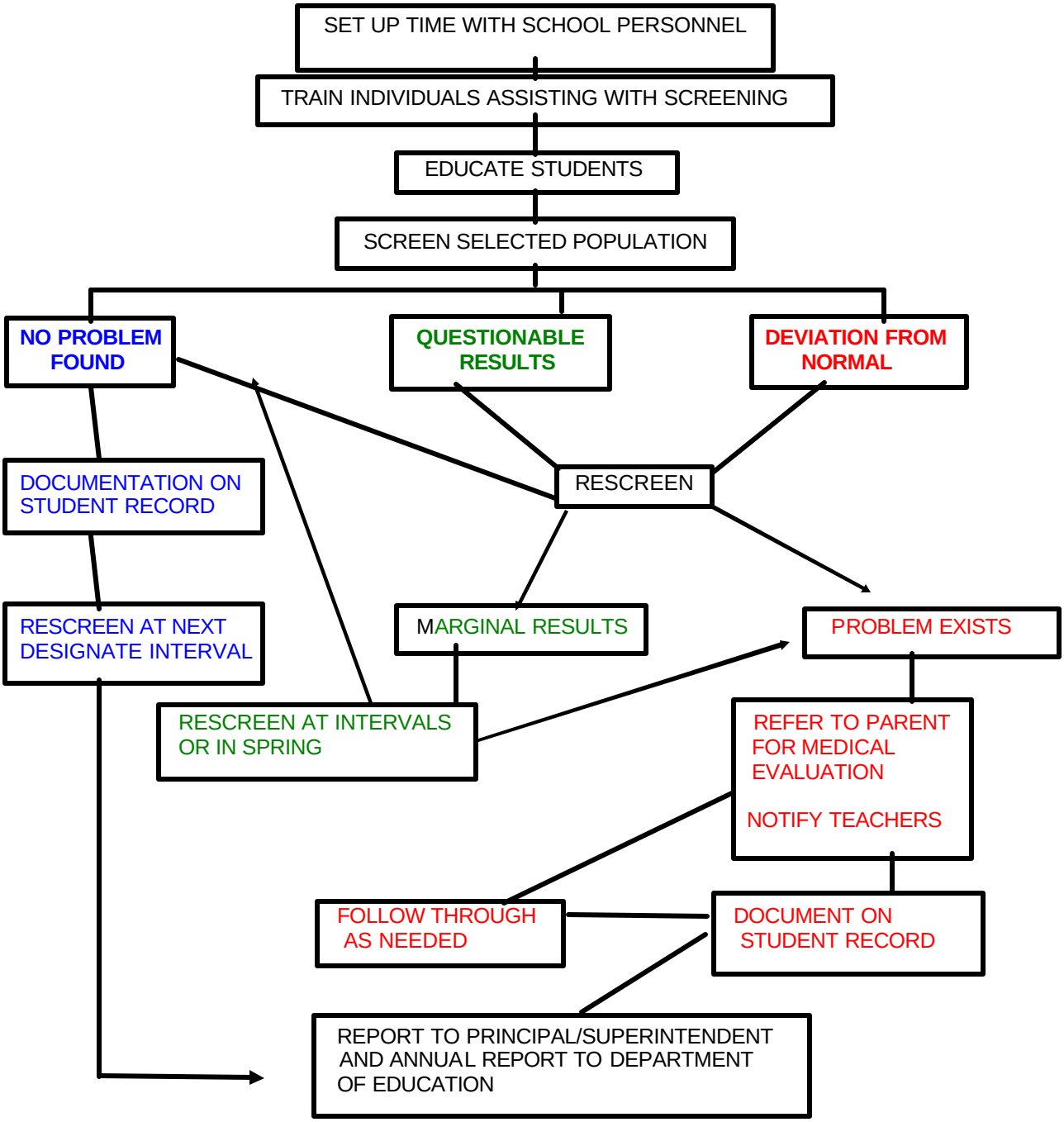
1. Changes in growth pattern of two percentile levels or more based on the chronological age of the student.
2. A differential of two percentile levels between height and weight.
3. CDC Body Mass Index (BMI) for Age and Gender Growth Charts indicating that the student is at risk for being overweight or being underweight.
4. If a student is unable to be screened.

## CRITERIA FOR REFERRAL – BLOOD PRESSURES

1. If after three blood pressure readings, two out of the three readings are at the 90th percentile or above for the student's age.
2. Immediate referral is indicated if the systolic pressure is above 150 or the diastolic pressure is above l00.
   If a student is unable to be screened.

## SCREENING PROGRAM FLOW CHART

Administering a Health Screening Program in the School Setting Can Include the Steps Depicted Below:



## REQUIRED AND OPTIONAL SCREENING

**RQ** Screening exams required by Vermont Law

**OP** Optional screening exams

| SCREENING | | GRADE | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **PK** | **K** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** |
| **HEARING** | | | OP | RQ | RQ | RQ | | RQ | | RQ | | RQ | | | |
| **VISION** | **Phoria** | | OP | OP | OP | OP | OP | | | | | | | | |
| | **Visual Acuity** | | OP | RQ | OP | RQ | | RQ | | RQ | | RQ * | RQ * | | |
| | **Color Vision** | | OP | OP | | | | | | | | | | | |

* Screening is required in one of the two grades

**Mass screening – Hearing**

## HEARING SCREENING

| NAMES | RIGHT | | | | LEFT | | | | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|
| Class - | 500 | 1000 | 2000 | 4000 | 500 | 1000 | 2000 | 4000 | |
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**Mass screening – Vision**

## SCREENING VISION

| NAMES | G | FAR VISION | | PHORIA | | NEAR VISION | | COMMENTS |
|---|---|---|---|---|---|---|---|---|
| **Class -** | | RIGHT | LEFT | FAR | NEAR | RIGHT | LEFT | |
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## School Health Services - Health Screening Sample Referral Letter

Date:

Student Name:

Dear Parent/Guardian,

AS part of the health services program at _____ Elementary, health screening exams are done to detect problems that might interfere with your child's school performance or general health. The screening exams include: vision, hearing, height, weight, and blood pressure. These exams should not be a substitute for a regular physical exam by your doctor, which should be done at least every two years for children of school age. However, these exams do serve to identify problems that might come up between physicals.

The recent health screening on your child indicates that a possible vision problem exists. Further evaluation should be done by your doctor to determine if there is a problem that needs treatment. Test results are given below for you to share with the doctor.

**20/20 is normal vision.**

| **Vision Exam** | **EYE** | **Far Vision** | **Near Vision** | **Phoria** |
|---|---|---|---|---|
| 1st Exam | Right | | | |
| | Left | | | |
| 2nd Exam | Right | | | |
| | Left | | | |

Please make an appointment with your doctor to have this checked. When your child is seen by the doctor, please have the attached form filled out. Then return the form to the school, so we may know the findings and recommendations. If finances are a problem, the State sponsors the Doctor Dynasaur Program (1-800-244-2035 see enclosed brochure) to assist financially in providing health care for children up to 18 years old. Thank you for your attention to this matter. Please feel free to call me at school on Thursdays (phone number) if you have any questions.

Sincerely,

School Nurse

# VISION GLOSSARY

**Accommodation** – The adjustment of the eye for seeing at different distances, accomplished by changing the shape of the crystalline lens through action of the ciliary muscle, thus focusing a clear image on the retina.

**Albinism -** Lack of pigment in the iris, skin, and hair; usually associated with lowered visual acuity, nystagmus, and photophobia, and often accompanied by refractive errors.

**Amblyopia -** Dimness of vision. Amblyopia ex-anopsia is amblyopia due to disuse of the eye.

**Ametropia -** Imperfection in the refractive powers of the eye so that images are not brought to a proper focus on the retina; includes hyperopia, myopia, and astigmatism.

**Astigmatism** - A defect of curvature of the cornea of the eye as a result of which a ray of light is not sharply focused on the retina but is spread over a more or less diffused area. This results in the formation of a distorted image.

**Binocular Vision** - The ability to use the two eyes simultaneously to focus on the same object and to fuse the two images into a single image which gives a correct interpretation of its solidity and its position in space.

**Blepharitis** - Inflammation of the margin of the eyelids.

**Blindness -** In the United States, the legal definition of blindness is: Central visual acuity of 20/200 or less in the better eye after correction; or visual acuity of more than 20/200 if there is a field defect in which the wide diameter of the visual field subtends an angle distance no greater than 20°. Some states include up to 30°.

**Blind Spot** - An area which has no nerve receptors, located at the back of the eye where the optic nerve enters the eye to supply nerve fibers and blood vessels to the retina. The blind spot in one eye does not "correspond" to the other so that the vision of one eye "fills in" the blind spot of the other, and vice versa.

**Cataract** - A condition in which the crystalline lens of the eye, or its capsule, or both, become opaque, with consequent loss of visual acuity.

**Chalazion** - Inflammatory enlargement of a meibomian gland in the eyelid.

**Color Deficiency** - Inability to perceive differences in color, usually for red or green, rarely for blue or yellow. Condition exists in varying degrees from minor loss to complete color blindness.

**Concave Lens** - Lens having the power to diverge parallel rays of light; also known as diverging, reducing, negative, myopic, or minus lens, denoted by the sign - .

**Cones** - One of the two types of light-sensitive nerve endings scattered over the surface of the retina making it possible to transmit visual impulses to the brain. Cones perceive fine detail and color and are more numerous at the back of the eye.

**Conjunctiva -** Mucous membrane that lines the eyelids and covers the front part of the eyeball.

**Conjunctivitis -** Inflammation of the conjunctiva.

**Contact of Corneal Lenses** - A thin curved shell of glass or plastic applied directly on the eyeball to correct refractive errors.

**Convergence** - The process of directing the visual axes of the two eyes to a near point, with the result that the pupils of the two eyes are closer together. The eyes are turned inward.

**Convex Lens** - Lens having power to converge parallel rays of light and to bring them to a focus; also known as converging, magnifying, hyperopic, or plus lens, denoted by the sign + .

**Cornea** - The anterior transparent portion of the outer coat of the eye through which light enters.

**Dark Adaptation** - The ability of the eye to adjust itself to dim lights.

**Depth Perception** - The ability to perceive the solidity of objects and their relative position in space Synonym - stereoscopic vision.

**Diopter -** A unit of measurement denoting the amount a lens can bend a light ray in a distance of one meter. A term used to describe the strength of a lens or the deviation of an eye in or out.

**Diplopia** - Double vision.

**Divergence** - The ability to relax convergence, or the ability to turn the eyes out.

**Emmetropia -** The refractive condition of the normal eye.

**Enucleation -** Complete surgical removal of the eyeball.

**Esophoria -** A tendency of the eye to turn inward.

**Estropia -** A manifest or observable turning inward of the eye (convergent strabismus or crossed eye).

**Exophoria** - A tendency of the eye to turn outward.

**Exophthalmos** - A condition in which the eyeballs protrude or bulge abnormally from their sockets.

**Exotropia** - A manifest or observable turning outward of the eye (divergent strabismus or wall eye).

**Eye Dominance** - Tendency of one eye to assume the major function of seeing, being assisted by the less dominant eye.

**Field of Vision** - The entire area that can be seen at one time without shifting the head or eyes.

**Floaters -** Small particles which float in the vitreous and may be seen by the individual.

**Focus Point** - at which rays are converged after passing through a refractive substance. Focal distance is the distance rays travel after refraction before focus is reached.

**Foot-Candle** - Unit of measurement of light intensity; the amount of light shed by a standard candle at a distance of one foot.

**Fusion -** Coordination of the images seen by each eye individually into one picture.

**Glaucoma** - Disease of the eye marked by increased intraocular pressure resulting in hardness of the eyeball; can cause blindness.

**Hordeolum -** see Stye.

**Hyperopia** - A refractive error in which the eyeball is too short from front to back or the refractive power of the eye too weak, so that parallel rays of light are brought to a focus behind the retina. Farsightedness, a condition requiring a convex (plus) lens to correct.

**Hyperphoria** - A tendency of one eye to deviate upward.

**Hypertropia -** A manifest or observable deviation upward of one of the eyes.

**Ishihara Color Plates** - A test for color vision made by the use of a series of plates composed of round dots of various sizes and colors.

**Light Adaptation** - A test for color vision made by the use of a series of plates composed of round dots of various sizes and colors.

**Monocular** - Pertaining to or having one eye.

**Myopia** - A refractive error in which the eyeball is too long or the refractive power too strong, so that parallel rays of light are focused in front of the retina. Near-sightedness - a condition requiring a concave (minus) lens to correct.

**Near Vision -** The ability to perceive distinctly objects at normal reading distances, or about fourteen inches from the eyes.

**Night Blindness** - A condition in which the sight is good by day but deficient at night and in any faint light.

**Nystagmus -** An involuntary, rapid movement of the eyeball; may be lateral, vertical, rotary or mixed.

**Occlusion** - The method of obscuring the vision of one eye, so as to force the use of the other eye.

**Oculus Dexter** - (O.D.) Right eye.

**Oculus Sinister** - (O.S.) Left eye.

**Oculus Uterque** - (O.U.) Both eyes.

**Ophthalmologist -** A physician who specializes in the branch of medical science dealing with the structure, functions, and diseases of the eye.

**Optometrist** - A specialist in the art or profession of examining the eye for defects and faults of refraction and prescribing correctional lenses or exercises, but not drugs or surgery.

**Partially Seeing Child -** For educational purposes, a partially seeing child is one who has a visual acuity of 20/70 or less in the better eye after the best possible correction, and who can use vision as his chief channel of learning.

**Peripheral Vision** - Ability to perceive presence, motion, or color of objects outside of the direct line of vision.

**phoria** - A suffix root denoting a latent deviation in which the eyes have a constant tendency to turn from the normal position, used with a prefix to indicate the direction of such deviation (hyperphoria, up; esophoria, in; exophoria, out).

**Photophobia -** Abnormal sensitivity to and discomfort from light.

**Plus Sphere Lens** - Lens made by using prisms to converge light rays so that they come to a focus nearer the front of the eye, thus allowing a shorter eyeball to see an image more clearly; often written: sphere.

**Ptosis -** The permanent drooping of the upper eyelid.

**Refraction** -

a. Deviation in the course of rays of light in passing from one transparent medium into

another of different density.

b. Determination of refractive errors of the eye and correction by glasses.

**Refractive Error** - A defect in the eye that prevents light rays from being brought to a single focus exactly on the retina.

**Retinitis** - Inflammation of the retina.

**Retinitis Pigmentosa** - A chronic, progressive degeneration (usually hereditary) consisting of atrophy of the retina with characteristic deposits of pigment.

**Retinoblastoma** - The most common malignant intraocular tumor of childhood which occurs usually under age 5, is probably always congenital, and may require removal of the eye.

**Retrolental Fibroplasia** - A condition in which there is a pathological dilation of the retinal vessels, retinal exudation, detachment, and the formation of a retrolental membrane. This usually occurs in premature infants, particularly those who received supplemental oxygen.

**Rods -** One of the two types of light-sensitive nerve endings that are scattered over the surface of the retina making it possible to transmit visual impulses to the brain. Rods perceive light and motion.

**Safety Glasses -** Impact-resistant lenses available with or without visual correction for workshop or street wear protection, for both adults and children.

**Scotoma - A** blind or partially blind area in the visual field other than the true blind spot. There may be more than one present, and then they are called scotomata.

**Stereopsis -** Fine depth perceptions, arising from binocular vision.

**Strabismus** Tropia or squint; failure of the two eyes to simultaneously direct their gaze at the same object because of muscle imbalance; a misalignment of the eyes.

**Stye -** Acute inflammation of a sebaceous gland in the margin of the eyelid, due to infection and usually resulting in the formation of pus.

**Suppression** - The voluntary or involuntary non-use of vision, usually by one eye, when both eyes are open but not occluded.

**Suppressing** - The act of accepting the image seen with one eye and ignoring that seen with the other eye.

**tropia -** A root word denoting a manifest or observable deviation from normal of the axis of the eye (strabismus), used with a prefix to denote the type of strabismus, as

heterotropia, esotropia, exotropia.

**Tunnel Vision** (Gun-Barrel, Tubular) - Narrowing of the visual field to such an extent that only a small area of central visual activity remains, thus giving the affected individual the impression of looking through a tunnel.

**Uveitis** - Inflammation of the uveal tract.

**Visual Acuity** - Sharpness of vision in respect to ability of the eye to distinguish detail as an object is placed further away or as it becomes small in size.

## DEFINITIONS OF VISUALLY HANDICAPPED CONDITIONS

A visually handicapped child is any child who needs special intervention or materials in the classroom because of a visual difficulty. The following are specific terms which describe visually handicapping conditions:

**Totally Blind** – An extremely small percentage of visually handicapped individuals are actually totally blind. Many have some sort of light, form or movement perception. However, many children who are Braille readers are often referred to as “totally blind,” since they cannot use large-print materials.

**Legally Blind -** "Legally Blind" is a legal term which describes a person as blind if he/she has a central visual acuity of 20/200 or less in the better eye, after correction; or central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees.

**Low Vision -** Children having a visual acuity of 20/70 or less in the better eye after all necessary medical or surgical treatment has been given and compensating lenses provided when the need for them is indicated. Such children are often referred to as "partially sighted" and must have a residue of sight that makes it possible to use sight as the chief avenue of approach into the brain.

These children with a visual deviation from the normal can benefit from the special educational facilities provided for those with low vision.*

* Please note that there are children who may have a visual acuity indicating high visual functioning, but when using their vision in the educational setting have a substantial problem with visual functioning. Assistance of the eye specialist and a vision specialist certified in the Education of the Visually Handicapped should be sought to evaluate visual functioning.

These definitions of blindness are from: Training for School Vision Screening: Regional Approach Model. Region XV Education Service Center, developed under the auspices of the Governors Coordinating Office for the Visually Handicapped and the Department of Special Education at the University of Texas in Austin, 1978.

**Screening Forms - Mass screening – Height, Weight and Blood Pressure**

## BLOODPRESSURE SCREENING

| NAMES | BP | AGE | RESCREENING |
|---|---|---|---|
| **Kindergarten - PM** | | | |
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## School Health Services - Health Screening Referral for Blood Pressure

Date:

Student Name:

Dear Parent/Guardian,

As part of the health services program at _____ Elementary, health screening exams are done to detect problems that might interfere with your child's school performance or general health. The screening exams include: vision, hearing, height, weight, and blood pressure. These exams should not be a substitute for a regular physical exam by your doctor, which should be done at least every two years for children of school age. However, these exams do serve to identify problems that might come up between physicals.

The recent health screening on your child indicates that a possible blood pressure problem exists. Out of the four blood pressures taken, your child's blood pressure was elevated (according to the guidelines provided for school health services by the State) on three separate occasions. Further evaluation should be done by your doctor to determine if there is a problem that needs treatment. Test results are given below for you to share with the doctor.

Initial Blood Pressure _____Date_____

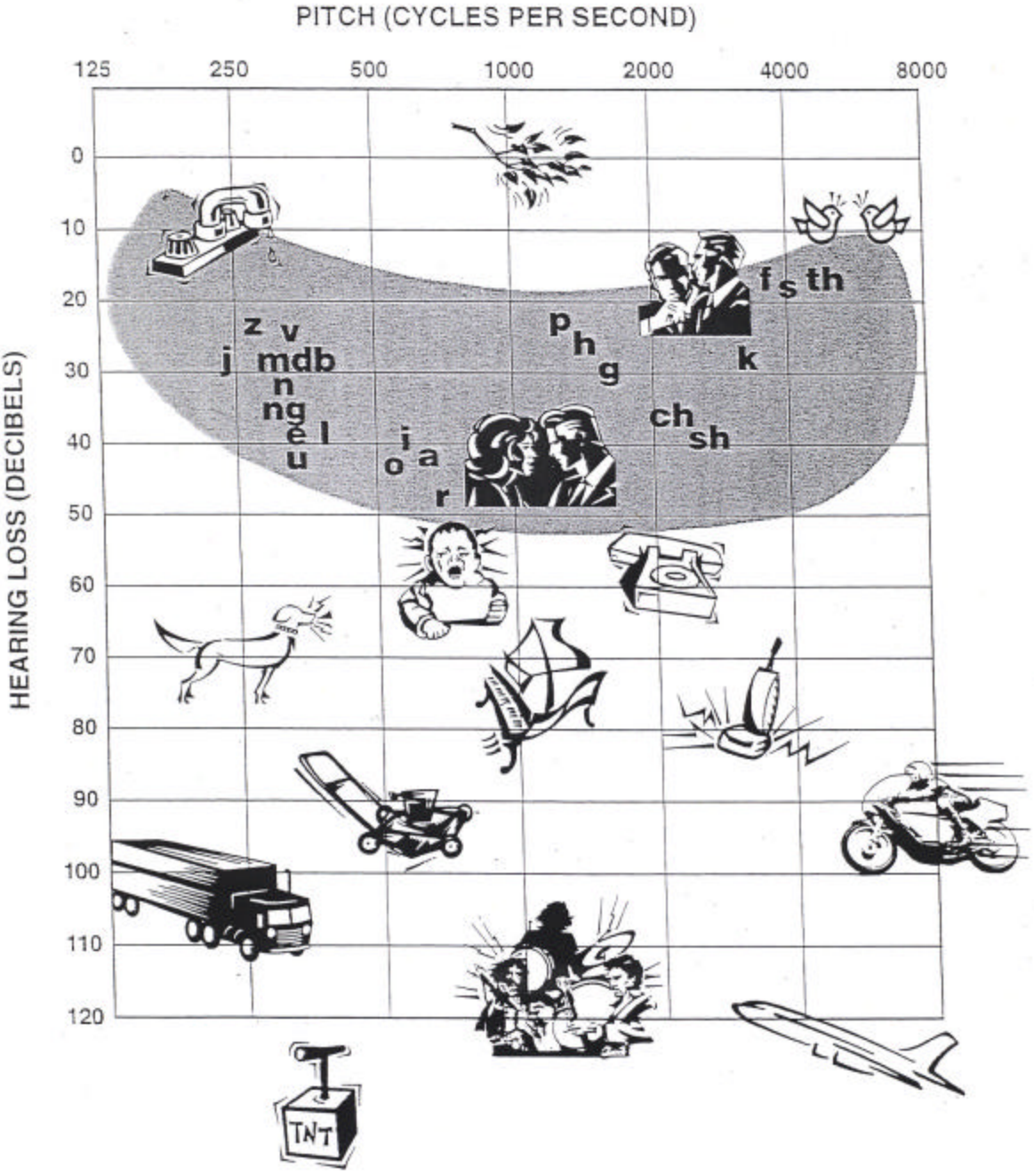
| Follow-up Screening | 1st | 2nd | 3rd |
|---|---|---|---|
| Right arm | | | |
| Left arm | | | |

Please make an appointment with your doctor to have this checked. When your child is seen by the doctor, please have the attached form filled out. Then return the form to the school, so we may know the findings and recommendations. If finances are a problem, the State sponsors the Doctor Dynasaur Program (1-800-244-2035 see enclosed brochure) to assist financially in providing health care for children up to 18 years old. Thank you for your attention to this matter. Please feel free to call me at school on Thursdays if you have any questions.

Sincerely,

School Nurse

# AUDIOGRAM OF FAMILIAR SOUNDS



**STATE OF VERMONT**
**DEPARTMENT OF EDUCATION**
**120 State Street**
**Montpelier, VT 05620-2501**

**To:** **School Nurses**

**From:** **Shevonne Travers, Coordinator, Coordinated School Health Programs and Nancy Wible, Consultant School Health Services**

**Date:** **January 22, 2003**

**Subject:** **Hearing and Vision Screening of Students with Disabilities**

Recently a student with disabilities was not provided vision and hearing screening because the school health professional could not provide appropriate accommodations to properly screen the student. There may be some circumstances that prevent proper screening. The issue in this situation was that the parents of the student were not informed the student had not been screened.

Schools are required by law (16 V.S.A. §1422) to provide hearing and vision screening to ***all*** students in grades 1, 2, 3, 5, 7 and 9 and to "any student who appears to have defective vision or hearing, at any time there appears to be a need for such a test." The Department strongly recommends that students on 504 Plans or IEP's, whose disability may have an effect on vision or hearing, be screened more frequently (i.e. annually) than the law requires and that educational support teams, 504 teams and IEP teams be informed of the results of screening.

In an effort to ensure that students' vision and hearing problems do not go uncorrected, it is further recommended that, subsequent to the vision or hearing screenings, all parent(s) be notified of the screening results in writing. Parents should be informed if the student needs further assessment by a hearing or vision specialist. In cases like the one above, they should also be informed that the student was unable to be screened because of a physical impairment, behavioral issue or because he/she was absent.

Thank you for your attention to this matter. Questions or clarifications regarding this issue should be addressed to Nancy Wible, School Health Services Consultant. She can be reached at nwible@doe.state.vt.us or by calling 828-5180.

cc: J. Douglas Dows, Director, Safe and Healthy Schools Team
Dennis Kane, Director, Student Support Team
Special Education Administrators
Superintendents

# RELATIONSHIP OF DEGREE OF LONGTERM HEARING LOSS TO PSYCHOSOCIAL IMPACT AND EDUCATIONAL NEEDS

| Degree of Hearing Loss<br>Based on modified pure tone average (500-4000 HZ) | Possible Effect of Hearing Loss on the Understanding of Language & Speech | Possible Psychosocial Impact of Hearing Loss | Potential Educational Needs and Programs |
|---|---|---|---|
| **NORMAL HEARING**<br>-10 - +15 dB HL | Children have better hearing sensitivity than the accepted normal range for adults. A child with hearing sensitivity in the -10 to +15 dB range will detect the complete speech signal even at soft conversation levels. However, good hearing does not guarantee good ability to discriminate speech in the presence of background noise. |  |  |
| **MINIMAL (BORDERLINE)**<br>16-25 dB HL | May have difficulty hearing faint or distant speech. At 15 dB student can miss up to 10% of speech signal when teacher is at a distance greater than 3 feet and when the classroom is noisy, especially in the elementary grades when verbal instruction predominates. | May be unaware of subtle conversational cues which could cause child to be viewed as inappropriate or awkward. May miss portions of fast-paced peer interactions which could begin to have an impact on socialization and self concept. May have immature behavior. Child may be more fatigued than classmates due to listening effort needed. | May benefit from mild gain/low MPO hearing aid or personal FM system dependent on loss configuration. Would benefit from soundfield amplification if classroom is noisy and/or reverberant. Favorable seating. May need attention to vocabulary or speech, especially with recurrent otitis media history. Appropriate medical management necessary for conductive losses. Teacher requires inservice on impact of hearing loss on language development and learning. |
| **MILD**<br>26-40 dB HL | At 30 dB can miss 25-40% of speech signal. The degree of difficulty experienced in school will depend upon the noise level in classroom, distance from teacher and the configuration of the hearing loss. Without amplification the child with 35-40 dB loss may miss at least 50% of class discussions, especially when voices are faint or speaker is not in line of vision. Will miss consonants, especially when a high frequency hearing loss is present. | Barriers beginning to build with negative impact on self esteem as child is accused of "hearing when he or she wants to," "daydreaming," or "not paying attention." Child begins to lose ability for selective hearing, and has increasing difficulty suppressing background noise which makes the learning environment stressful. Child is more fatigued than classmates due to listening effort needed. | Will benefit from a hearing aid and use of a personal FM or soundfield FM system in the classroom. Needs favorable seating and lighting. Refer to special education for language evaluation and educational follow-up. Needs auditory skill building. May need attention to vocabulary and language development, articulation or speechreading and/or special support in reading. May need help with self esteem. Teacher inservice required. |
| **MODERATE**<br>41-55 dB HL | Understands conversational speech at a distance of 3-5 feet (face-to-face) only if structure and vocabulary controlled. Without amplification the amount of speech signal missed can be 50% to 75% with 40 dB loss and 80% to 100% with 50 dB loss. Is likely to have delayed or defective syntax, limited vocabulary, imperfect speech production and an atonal voice quality. | Often with this degree of hearing loss, communication is significantly affected, and socialization with peers with normal hearing becomes increasingly difficult. With full time use of hearing aids/FM systems child may be judged as a less competent learner. There is an increasing impact on self-esteem. | Refer to special education for language evaluation and for educational follow-up. Amplification is essential (hearing aids and FM system). Special education support may be needed, especially for primary children. Attention to oral language development, reading and written language. Auditory skill development and speech therapy usually needed. Teacher inservice required. |

| Degree of Hearing Loss | Possible Effect of Hearing Loss on the Understanding of Language and Speech | Possible Psychosocial Impact of Hearing Loss | Potential Educational Needs and Programs |
|---|---|---|---|
| **MODERATE TO SEVERE** 56-70 dB HL | Without amplification, conversation must be very loud to be understood. A 55 dB loss can cause child to miss up to 100% of speech information. Will have marked difficulty in school situations requiring verbal communication in both one-to-one and group situations. Delayed language, syntax, reduced speech intelligibility and atonal voice quality likely. | Full time use of hearing aids/FM systems may result in child being judged by both peers and adults as a less competent learner, resulting in poorer self concept, social maturity and contributing to a sense of rejection. Inservice to address these attitudes may be helpful. | Full time use of amplification is essential. Will need resource teacher or special class depending on magnitude of language delay. May require special help in all language skills, language based academic subjects, vocabulary, grammar, pragmatics as well as reading and writing. Probably needs assistance to expand experiential language base. Inservice of mainstream teachers required. |
| **SEVERE** 71-90 dB HL | Without amplification may hear loud voices about one foot from ear. When amplified optimally, children with hearing ability of 90 dB or better should be able to identify environmental sounds and detect all the sounds of speech. If loss is of prelingual onset, oral language and speech may not develop spontaneously or will be severely delayed. If hearing loss is of recent onset speech is likely to deteriorate with quality becoming atonal. | Child may prefer other children with hearing impairments as friends and playmates. This may further isolate the child from the mainstream, however, these peer relationships may foster improved self concept and a sense of cultural identity. | May need full-time special aural/oral program for with emphasis on all auditory language skills, speechreading, concept development and speech. As loss approaches 80-90dB, may benefit from a Total Communication approach, especially in the early language learning years. Individual hearing aid/personal FM system essential. Need to monitor effectiveness of communication modality. Participation in regular classes as much as beneficial to student. Inservice of mainstream teachers essential. |
| **PROFOUND** 91 dB HL or more | Aware of vibrations more than tonal pattern. Many rely on vision rather than hearing as primary avenue for communication and learning. Detection of speech sounds dependent upon loss configuation and use of amplification. Speech and language will not develop spontaneously and is likely to deteriorate rapidly if hearing loss is of recent onset. | Depending on auditory/oral competence, peer use of sign language, parental attitude, etc., child may or may not increasingly prefer association with the deaf culture. | May need special program for deaf children with emphasis on all language skills and academic areas. Program needs specialized supervision and comprehensive support services. Early use of amplification likely to help if part of an intensive training program. May be cochlear implant or vibrotactile aid candidate. Requires continual appraisal of needs in regard to communication and learning mode. Part-time in regular classes as much as beneficial to student. |
| **UNILATERAL** One normal hearing ear and one ear with at least a permanent mild hearing loss | May have difficulty hearing faint or distant speech. Usually has difficulty localizing sounds and voices. Unilateral listener will have greater difficulty understanding speech when environment is noisy and/or reverberant. Difficulty detecting or understanding soft speech from side of bad ear, especially in a group discussion. | Child may be accused of selective hearing due to discrepancies in speech understanding in quiet versus noise. Child will be more fatigued in classroom setting due to greater effort needed to listen. May appear inattentive or frustrated. Behavior problems sometimes evident. | May benefit from personal FM or soundfield FM system in classroom. CROS hearing aid may be of benefit in quiet settings. Needs favorable seating and lighting. Student is at risk for educational difficulties. Educational monitoring warranted with support services provided as soon as difficulties appear. Teacher inservice is beneficial. |

**NOTE: All children with hearing loss require periodic audiologic evaluation, rigorous monitoring of amplification and regular monitoring of communication skills. All children with hearing loss (especially conductive) need appropriate medical attention in conjuction with educational programming.**

**REFERENCES**

Olsen, W. O., Hawkins, D. B. VanTassell, D. J. (1987). Representatives of the Longterm Spectrum of Speech. Ear & Hearing, Supplement 8, pp. 100-108.

Mueller, H. G. & Killion, M. C. (1990). An easy method for calculating the articulation index. The Hearing Journal, 43, 9, pp. 14-22.

Hasenstab, M. S. (1987). Language Learning and Otitis Media. College Hill Press, Boston, MA.

Developed by
Karen L. Ar on, Ed.S & Noel D. Matkin, Ph.D (1991)

**Adapted from:** Bernero, R. J. & Bothwell, H. (1966). Relationship of Hearing Impairment to Educational Needs. Illinois Department of Public Health & Office of Superintendent of Public Instruction.
**Peer Review** mbers of the Educational Audiology Association, Winter 1991

# STUDENTS WITH SPECIAL HEALTH NEEDS

## STATEMENT OF PURPOSE:

Schools must provide all students free and appropriate public education in the least restrictive environment.

## AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 99 § 2901 – Success for all students in the general education environment
- 16 V.S.A. Chapter 99 § 2902 – Educational support system
- 16 V.S.A. Chapter 99 § 2904 - Reports
- 16 V.S.A. Chapter 101 § 2941-2942 – Special education definitions
- 26 V.S.A. Chapter 28 – Nurse Practice Act
- 33 V.S.A. Chapter 43 § 4305 – Coordinated system of care
- 29 U.S.C. § 504 and § 794 – Nondiscrimination under federal grants and programs
- State Board of Education Manual of Rules and Practice, Section 1251 - Reasonable Accommodations
- State Board of Education Manual of Rules and Practice, Section 1252 - Instruction for Homebound and Hospitalized Students

## DEFINITIONS:

**Individualized Health Care Plan** – a plan which delineates:

a) The student's health care needs, related adaptations required in school and the individuals responsible for service delivery and assuring safety.
b) Designation of school liaison for family.
c) Time specifications for review and evaluation of the plan.

## REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Be knowledgeable of health conditions and related health care procedures.
2. Assist the family to identify the student's health related barriers to learning.
3. Communicate with health care providers to exchange relevant information.
4. Establish an Individual Health Care Plan (IHP) and protocols based on the student's identified needs.
5. Delegate health care tasks as indicated using established protocols.
6. Provide training, supervision and evaluation for personnel meeting the needs of specific students.

## SUGGESTEDED SCHOOL NURSE ROLE:

Participate on IEP, 504 and ESS teams.

## RESOURCES:


- American Diabetic Association – http://www.diabetes.org
- Arnold, M. J., & Silkworth, C. K. (Eds.). (1999). The School Nurse's Source Book of Individualized Healthcare Plans Vol. II. North Branch, MN: Sunrise River Press.
- Asthma and Allergy Foundation of America – http://www.aafa.org/
- Epilepsy Association of Vermont – P.O. Box 6292, Rutland, VT 05702, 802-775-1686
- Epilepsy Foundation of America – www.efa.org
- Hass, M. (Ed.). (1993). The School Nurse's Source Book of Individualized Healthcare Plans Vol. 1. North Branch, MN: Sunrise River Press.
- Hootman, J. (1996). Quality Nursing Interventions in the School Setting: Procedures Models, and Guidelines. Scarborough ME: National Association of School Nurses.
- National Association of School Nurses website - http://www.nasn.org/
- Ruston, C. H., Will, J.C., & Murray, M.G. (1994). To Honor and Obey – DNR Orders and the School. Pediatric Nursing, 20 (6), 581-585.
- Schwab, N, & Gelfman, M.H. (2001). Legal Issues in School Health Services. North Branch , MN: Sunrise River Press
- Section 504 of the Rehabilitation Act of 1973 & Vermont Schools. (2002). Montpelier, VT: Vermont Department of Education.
- Vermont Association for the Blind and Visually Impaired - http://www.vabvi.org
- Vermont Department of Health - Division of Health Improvement: Children with Special Health Needs - http://www.healthyvermonters.info/hi/cshn/cshn.shtml
- Vermont Department of Health - Division of Health Improvement: Children with Special Health Needs – Hearing Health and Communications Program
- Vermont Department of Health Diabetes Control Program. (1999). Recommendations for Management of Diabetes for Children in School. Burlington, VT: Vermont Department of Health.
- Vermont Department of Health. (2003). Managing Asthma at School. Vermont Department of Health.
- Vermont Division for the Blind and Visually Impaired - http://www.dad.state.vt.us/dbv


## SAMPLE POLICES, PROCEDURES AND FORMS:

- Do Not Resuscitate Orders (DNR)
- Emergency Form for Children with Special Needs
- Helping Hard of Hearing
- Individual Health Plan
- Sample Student Accommodation Plan

# DO NOT RESUSCITATE ORDER

Student's Name_____
(Please Type or Print)

Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female

Physician's Name:_____ Telephone:_____

Physician's Address: _____

---

We hereby direct_____School's personnel to withhold **cardiopulmonary resuscitation (CPR), artificial ventilation, or other related life sustaining procedures in the event of cardiac or respiratory arrest of the aforementioned child.**

We understand that palliative care in the form of: control of bleeding, airway maintenance, appropriate nutrition, control of pain, positioning for comfort and other measures to ensure general comfort will be provided, as previously ordered, or as indicated by school procedures. When authorized by physician order and parental permission on the standard medication form, prescription medications will also be provided.

Other measures that are allowable are:

____ Suctioning as necessary, using_____Fr. catheter at _____ml. water
____ Oxygen administration, as needed, via_____ at_____ mm. mercury
____ Other: _____

We understand that the Emergency Medical Services System (911) will be activated in response to a real or perceived emergency occurrence at school.

In the event of cardiorespiratory arrest at school, the following persons should be notified, in this order:

1. _____Telephone:_____
2. _____Telephone:_____
3. _____Telephone:_____
4. _____Telephone:_____

We understand that this order must be renewed every six months.

Other comments: _____

_____

_____

| _____ | _____ | _____ |
|---|---|---|
| *Date* | *Physician Signature* | *State License Number* |
| _____ | _____ | |
| *Date* | *Parent/Guardian Signature* | |

# Emergency Information Form for Children With Special Needs

American College of Emergency Physicians®

American Academy of Pediatrics

| | | |
|---|---|---|
| Date form completed | Revised | Initials |
| By Whom | Revised | Initials |

| | | |
|---|---|---|
| **Name:** | **Birth date:** | **Nickname:** |
| **Home Address:** | **Home/Work Phone:** | |
| **Parent/Guardian:** | **Emergency Contact Names & Relationship:** | |
| **Signature/Consent*:** | | |
| **Primary Language:** | **Phone Number(s):** | |

**Physicians:**

| | |
|---|---|
| **Primary care physician:** | **Emergency Phone:** |
| | **Fax:** |
| **Current Specialty physician:** | **Emergency Phone:** |
| **Specialty:** | **Fax:** |
| **Current Specialty physician:** | **Emergency Phone:** |
| **Specialty:** | **Fax:** |
| **Anticipated Primary ED:** | **Pharmacy:** |
| **Anticipated Tertiary Care Center:** | |

## Diagnoses/Past Procedures/Physical Exam:

**1.**

**2.**

**3.**

**4.**

**Synopsis:**

**Baseline physical findings:**

**Baseline vital signs:**

**Baseline neurological status:**

*Consent for release of this form to health care providers

**Diagnoses/Past Procedures/Physical Exam continued:**

| **Medications:** | **Significant baseline ancillary findings (lab, x-ray, ECG):** |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | **Prostheses/Appliances/Advanced Technology Devices:** |
| **5.** | |
| **6.** | |

**Management Data:**

| **Allergies: Medications/Foods to be avoided** | **and why:** |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **Procedures to be avoided** | **and why:** |
| **1.** | |
| **2.** | |
| **3.** | |

**Immunizations (mm/yy)**

| **Dates** | | | | | | | **Dates** | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DPT | | | | | | | Hep B | | | | | |
| OPV | | | | | | | Varicella | | | | | |
| MMR | | | | | | | TB status | | | | | |
| HIB | | | | | | | Other | | | | | |

Antibiotic prophylaxis: Indication: Medication and dose:

**Common Presenting Problems/Findings With Specific Suggested Managements**

| **Problem** | **Suggested Diagnostic Studies** | **Treatment Considerations** |
|---|---|---|
| | | |
| | | |
| | | |

Comments on child, family, or other specific medical issues:

| Physician/Provider Signature: | Print Name: |
| --- | --- |

# HELPING THE HARD OF HEARING PUPIL IN THE CLASSROOM

Children with a hearing loss are found occasionally in the school room by periodic audiometer testing or through the alertness of a teacher or nurse. Their hearing deficit varies in degree of severity. The hearing loss may be temporary, permanent or progressive.

Accommodations are made for students demonstrating a hearing loss, so that they may participate in all aspects of the educational program. Their needs are determined and arranged for through a conference of principal, nurse, teacher, psychologist, doctor and adviser in special education, who investigate the educational, personality and medical aspects of each case. Particular needs of each child govern the type of adjustment recommended.

A child having a moderate, permanent hearing deficiency may be seated closer to the teacher. The conferees may decide that the child needs lip-reading, as well as special seating. Another child may have lost his/her hearing at such an early age that special coaching in arithmetic, language, spelling or other subjects may be needed.

Children who have been especially designated for special seating or attention achieve more easily if the teacher observes some simple precautions. The following suggestions have been tried and found helpful:

1. The child with a hearing loss should be seated near the teacher in the front of the room. He/she should be allowed to shift his/her seat in order to follow the change in routine. This position will enable the child to see the teacher's face and to hear his/her voice more easily.

2. If the child's hearing loss involves only one ear, or if it is definitely greater in one ear than the other, seat the child in a front, corner seat so that his/her better ear is toward the class. Where both ears have the same loss, center placement is needed.

3. The child should be encouraged to watch the teacher whenever he/she is talking to the class.

4. During seat recitations, let the hard-of-hearing child turn around and face the class so he/she can see the lips of the reciter.

5. Whenever reports are given or during homeroom and class meetings, have the children stand in front of the class so that the hard-of-hearing child can see the lips of speakers.

6. The hard-of-hearing child must see your lips, therefore:
    a. Don't talk while writing on the blackboard.
    b. Don't stand with your back to the window while talking, (shadow and glare make it difficult to see your lips.)
    c. Keep your hand and books down from your face while speaking.
    d. Stand still while speaking and in a place with a normal amount of light on your face.
    e. Conduct class recitations and discussions from the front of the room.
    f. Be sure you have the child's attention before you give assignments or announcements.
    g. Don't expect the child to hear the assignments given without warning from a remote corner of the room while he/she is busy doing something else.
    h. Particular care must be used in dictating spelling. Use the words in sentences to show which of two similar words is meant, i.e. "Meet me after school" and "Give the dog some meat." Thirteen words look like "meat" when spoken such as been, bead and beet. The word "king" shows little or no lip movement. Context of the sentence gives the child the clue to the right word. Have the hard-of-hearing child say the words to himself/herself before a mirror while studying the spelling lesson.
    i. Ask the child if he/she understands after an extensive explanation of arithmetic problems or class discussion. Write key words of an idea or lesson on the chalkboard or on a slip of paper.
    j. Speak naturally. Don't exaggerate or over-emphasize. Gestures are distracting.
    k. If the heard-of-hearing child misunderstands, restate the question in a different way, as the chances are you are using words with invisible movements. Be patient and never skip the child. Be sure that things do not get past him/her.
    l. Give the child a chance to read ahead on the subject to be discussed. If he/she is familiar with the vocabulary it is easier to follow along.
    m. As the child acquires skill in lip reading, insist that he/she catch the assignments promptly. This will help him/her over difficult spots.

7. If the young hard-of-hearing child is poor in reading, chances are he/she needs basic phonics to improve both reading and speech.

8. Teach the child to use the dictionary with skill; to learn the pronunciation system so he/she can pronounce new words.

9. Build up the child's vocabulary by assigning supplementary materials.

10. We are likely to over-estimate the hearing efficiency of a child with a hearing loss because when he/she is paying close attention he/she apparently hears quite well. It is to be remembered that this child is hearing at the expense of a greater effort than the child expends who has normal hearing. It is to be expected that it will be more difficult to hold the attention of the hard-of-hearing child. Never forget that the heard-of hearing child gets fatigued sooner than other children because he/she not only has to use his/her eyes on all written and printed work, but also watch the lip movements of speakers.

11. Hearing of children varies, so don't think that inattention is always deliberate. Some children hear well in the fall, but are hard-of-hearing in the winter.

12. Encourage the child to participate in musical activities. This will stimulate residual hearing and add rhythm to speech. Have the child sit near a good singer. Explain the purpose of the seating to the latter. The hard-of-hearing child should participate in vocal music and choral reading.

13. A severe hearing loss that lasts over a period of time tends to result in a dull, monotonous voice and inaccurate enunciation. Therefore, that child should be encouraged to speak clearly. Keeping the child "speech conscious" will help him/her to resist the usual damage to the voice that a severe hearing loss produces. Don't let the child get the habit of shaking his/her head or speaking indistinctly instead of answering in complete sentences.

14. Since a hearing impairment affects the language processes, the child should be encouraged to compensate by a more active interest in all language activities; reading, spelling, original language, etc.

15. Enlist class cooperation in understanding the child's problem. Designate a student to be a helper in assignments so that someone knows the child is on the right page and doing the right exercise.

16. If a choice of teachers is possible, the child with a hearing loss should be placed with the teacher who enunciates clearly.

17. The child should be observed carefully to be sure that He/she is not withdrawing from the group or is not suffering a personality change as a direct result of the hearing loss. Be sure the child is "one of the gang."

18. Be natural with the hard-of-hearing child. He/she will appreciate it if he/she knows you are considerate of the hearing loss

19. In the lower grades, watch particularly that the child does his/her part and is not favored or babied.

20. Encourage the child to do their best. Maintain the child's confidence in you so he/she will be quick to report any difficulty.

21. Parents should know the truth about a child's achievement.

22. The child needs special encouragement when he/she passes from elementary to junior high school and later into senior high. The pace is swifter. There is much more discussion. Pupils relate to five or more instead of one teacher.

23. <u>The Hearing Aid</u>

a) Where a hearing aid has been suggested, see that the child wears it regularly, and that it is kept in good repair. In the early adjustment stages, this is perhaps the most valuable service you can render the child. (To check whether the instrument is working, remove the ear piece and place it against the microphone. You should get a whistling noise. If not, the battery, cord, or the instrument itself may be defective. Notify the parents.

b) If a child's hearing aid "whistle's" or "squeals"

(1) check the ear piece to make sure it is "in" properly;
(2) if the child is too close to the wall, window, or blackboard, move him/her away, since hard, smooth surfaces are highly reflective;
(3) the child's ear may be too close to the hearing aid itself caused by lowering his head.
(4) and, the volume may be too high. (He/she may have turned it up accidentally.)

c) He/she may need to be encouraged to keep the aid turned on. Some who are making a poor adjustment to wearing an aid, may have the ear piece in the ear but do not "tune in" because they fear "noises". They need to be encouraged to try to adjust to hearing.

25. <u>ALL SPECIAL CONSIDERATIONS THAT ARE SHOWN THE HARD-OF-HEARING SHOULD BE HANDLED SO AS NOT TO CALL ATTENTION TO THE DEFICIT</u>.

# CONFIDENTIAL
# INDIVIDUALIZED HEALTH PLAN

Last Name _____ First Name _____ Date of Birth _____

Grade/Teacher _____ Physician _____

Date-Plan was written _____ Name of Nurse _____

EMERGENCY PHONE NO. : 1. _____

& ORDER TO CALL 2 _____

Condition _____ Date of Last Episode _____

Medication _____

SYMPTOMS SCHOOL PERSONNEL SHOULD BE LOOKING FOR WHICH WOULD INDICATE A PROBLEM:

1. _____
2. _____
3. _____

COURSE OF ACTION SCHOOL PERSONNEL SHOULD FOLLOW:

1. _____
2. _____
3. _____

TRAINED STAFF & DATE OF TRAINING:

_____

_____

Signature of Parent/Guardian _____

Rev. 6/3/04

## Student 504 Accommodation Plan – Sample Plan #1

Name_____ Birth date:_____ Grade: _____
School: _____ Meeting Date: _____ Plan Coordinator: _____
In attendance: _____
_____
Nature of concern: _____
_____
Basis of determination of disability (if any): ___ none ___ physical/physiological ___ mental/psychological
Description of the basis for the determination of disability: _____
_____
_____
Major life activity substantially limited: _____
_____
_____

Reasonable, necessary accommodations

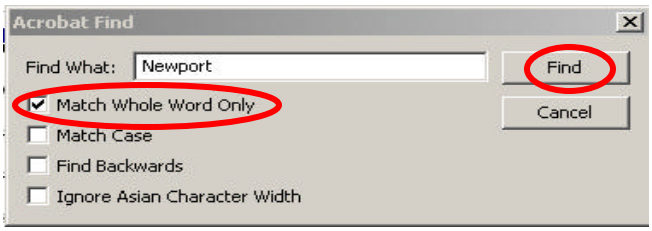
| Issues to target | Action to be taken | Person responsible | When/Frequency | How know it's working | Results |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Plan will be reviewed on (required): _____ by: _____ Plan will be given to: _____
Any funding or other resources (include source) needed to implement the plan: _____
_____
Other support(s) necessary for those implementing this plan (including family members) to be successful in addressing the students needs: _____
_____

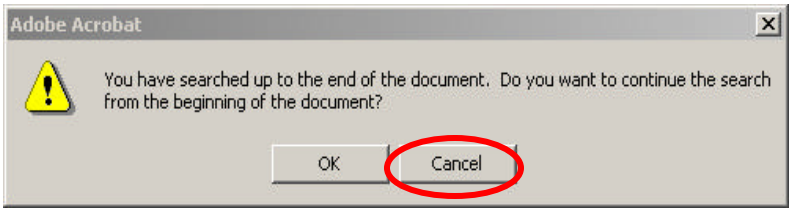
Currently there is not a hardcopy version of the index available. An electronic version may be found through the PDF version of the manual on the enclosed CD by following these three simple steps:

**Step 1.** After you open the Adobe Acrobat version of the manual, click on the **Binocular Icon** on the menu bar on top of your screen.


**Step 2.** The **Acrobat Find** box will appear. Type in the item you want to search for and check the **Match Whole Word Only** box, click **Find**. The first time the word appears in the document will be highlighted.




**Step 3.** Continue to search for the word by clicking on the **Binocular/Arrow Icon**. The next time the word appears, it will be highlighted. Continue this process until you reach the end of the document.

# Manual Revision Procedure

School nurses, health care providers, school administrators and Vermont Department oh Health representatives may submit a recommendation for manual revisions.

Please note the following steps:

1. The proposed revisions must be submitted in writing to the Department of Education School Health Services Consultant and the Chair of the School Health subcommittee of the Vermont Medical Society. The Department of Education School Health Services Consultant will forward these to the School Nurse Advisory Committee. The Vermont Medical Society School Health Chair will forward these to the Vermont Medical Society School Health Committee Members.

2. These reviewers will be asked to review and make recommendations within 30 days.

3. Approved revisions will be added to the manual prior to the beginning of the next school year.